Hoofbeats Therapeutic Riding Center, Inc.
P.O. Box 979, Lexington, VA 24450
Ph: (540) 464-3337
e-mail: info@hoof-beats.com
Website: www.hoof-beats.com

Form 6 – Medical History - Therapist

Dear Therapist, Health Professional, or Educator,

One of your clients/students has applied to receive therapeutic riding instruction at Hoofbeats Therapeutic Riding Center, Inc. this year. Please fill out the attached form to the best of your ability and answer all of those questions which fall within your area of expertise or about which you have some pertinent information. Your input will help us to decide whether this person will benefit from therapeutic riding and/or establish goals for a therapeutic riding plan. If you have any questions about this form, please call our instructors at the Hoofbeats office, 540-464-3337.

Please return the completed forms to the Hoofbeats office, or mail them to Hoofbeats Therapeutic Riding Center, Inc., P.O. Box 979, Lexington, VA 24450.

Information for Therapist
The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic
Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures Coxas
Arthrosis Heterotopic
Ossification Osteogenesis
Imperfecta Cranial Deficits
Spinal Orthoses
Internal Spinal Stabilization Devices

Neurologic
Hydrocephalus/shunt
Spina Bifida
Tethered Cord
Chiari II Malformation
Hydromyelia
Paralysis due to Spinal Cord Injury
Seizure Disorders

Medical/Surgical
Allergies Stroke (Cerebrovascular Accident)
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart Condition

Secondary Concerns
Behavior Problems (including a history of violence or abuse toward people or animals or pyromania)
Bipolar disorder
Schizophrenia Age
under 2 years Age
2-4 years
Acute exacerbation of chronic disorder
Indwelling catheter

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PARTICIPANT'S MEDICAL HISTORY/ THERAPIST'S STATEMENT
(To be completed by Health or Educational Professional other than M.D.)

Participant's Name: _____

Address: _____

Date of Birth: _____ Height: _____ Weight: _____

Name of Parent/Guardian/Adult Caregiver, if any: _____

Diagnosis: _____ Date of onset: _____

Current Therapy (last treatment, date, remarks):

Current Medications:

Please indicate if patient has a problem and/or surgery in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation: Yes ____ No ____ Crutches: Yes ____ No ____ Braces: Yes ____ No ____

Wheelchair: Yes ____ No ____

Client Name: _____

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PARTICIPANT'S MEDICAL HISTORY AND THERAPIST'S STATEMENT

Participant's Name: _____

Physical Function Assessment (mobility skills, range of motion, etc.):

Psycho/Social Function (i.e. emotional/mental health, behavioral issues, support systems, etc.):

Concerns/potential safety issues in a farm or therapeutic riding setting?

Therapeutic/Educational Goals? Include goals that might be addressed within the framework of a therapeutic riding lesson:

THERAPIST'S or EDUCATOR'S STATEMENT

Unless otherwise noted in this form, to my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. I understand that Hoofbeats Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications.

Therapist Name (Please Print): _____

Therapist Signature: _____ Date: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Specialty/Licensing: _____

State/Federal License Number, if applicable: _____

Client Name: _____