



## Participant's Medical History & Physician's Statement

Participant: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD10 \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Yes No Date of Last Seizure: \_\_\_\_\_

Shunt/Pacemaker or implanted device present: Yes No Type: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Ambulates independently With walker or cane Uses wheelchair

Prosthesis/Assistive Devices: \_\_\_\_\_

*Please indicate current or past special needs in the following systems/areas, including surgeries:*

	Y	N	Comments
Auditory			
Visual			
Tactile Sensations			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, **please note whether these conditions are present, and to what degree.**

**ORTHOPEDIC**

Atlantoaxial Instability – include neurologic symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

**OTHER**

Age – under 4 yrs  
Indwelling catheters  
Photosensitivity  
Poor Endurance  
Skin Breakdown

**NEUROLOGIC**

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

**MEDICAL/PSYCHOLOGICAL**

Allergies  
Animal abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Setting  
Heart Conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

Veteran Name: \_\_\_\_\_

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD DO NP PA Other

Signature: \_\_\_\_\_ Date:

Address:

Phone: (\_\_\_\_) \_\_\_\_\_ License/UPIN Number: \_\_\_\_\_