

Reins From Above Therapeutic Riding Center, Inc.

86 Polenta Road
Smithfield, NC 27577
Phone: 919-938-1556

Website: www.reinsfromabove.org

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

Date: _____

Participant's Name: _____ Date of Birth: _____

Address: _____

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

Diagnosis: _____ Date of onset: _____

Current Therapy (Last treatment, date, remarks): _____

Current Medications: _____

Please indicate if the client/student has a problem and/or surgeries 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 Please indicate any

special precautions _____

Name of Health/Education Professional: _____ Specialty/Licensing: _____

PARTICIPANT'S MEDICAL HISTORY AND THERAPIST'S STATEMENT

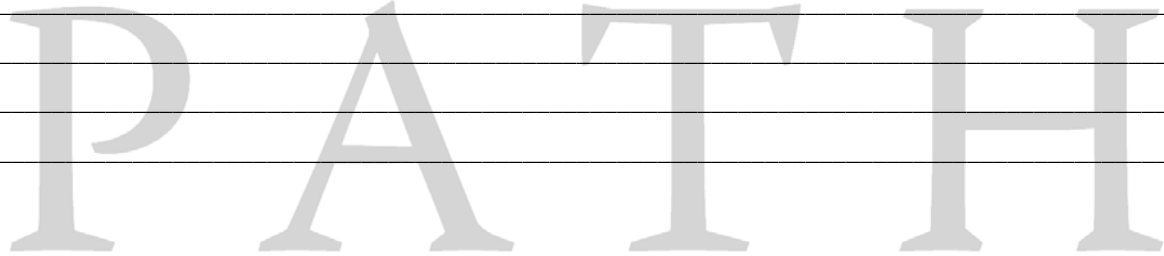
Participant's Name: _____

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 Reins From Above 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: _____ Socialty/Licensing: _____

State/Federal License Number, if applicable: _____



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Dear Therapist, Health Professional, or Educator,

One of your clients/students has applied to receive therapeutic riding instruction at Reins From Above 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 one of our instructors at 919-938-1556.

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	Medical/Surgical Allergies Cancer Poor Endurance Recent Surgery Diabetes Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension Serious Heart Condition Stroke (Cerebrovascular Accident)
Neurologic Hydrocephalus/shunt Spina Bifida Tethered Cord Chiari II Malformation Hydromyelia Paralysis due to Spinal Cord Injury Seizure Disorders	Secondary Concerns Behavior Problems Age under 2 years Age 2-4 years Acute exacerbation of chronic disorder Indwelling catheter

— MEMBER —