



Medical History & Physician Statement

(Must be completed by a physician)

Dear Physician,

Your patient _____ is interested in participating in supervised equestrian activities.

EquiCenter, Inc. requires you to complete the attached Medical History and Physician's Statement Form to provide this service safely. **Completed forms can be emailed to participantpaperwork@equicenterny.org or faxed to 585-684-7863.**

Please note that any sections left unfilled will be considered incomplete.

Date of Birth: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizures ☐ Yes ☐ No Type _____ Date of Last Seizure: _____

Shunt Present: ☐ Yes ☐ No Date of Last Revision: _____

Date of Last Hip Radiograph: _____ Result (please describe): _____

May require additional paperwork:

Scoliosis ☐ Yes ☐ No Type _____ Degree _____

Back Rod ☐ Yes ☐ No Placement _____



Participant's Name: _____

Seizures ☐ Yes ☐ No Type _____ Date of Last Seizure: _____

The participant's seizures are:

- ☐ Completely Controlled
- ☐ Well Controlled
- ☐ Fairly Controlled
- ☐ Uncontrolled

Mobility:

- Independent Ambulation: ☐ Yes ☐ No
- Assisted Ambulation: ☐ Yes ☐ No
- Wheelchair: ☐ Yes ☐ No
- Braces/Assistive Devices: ☐ Yes ☐ No

For those with Down Syndrome:

Neurologic symptoms of AtlantoAxial Instability: ☐ Present ☐ Absent
Atlanto Dens X-Rays Date: _____ Result: ☐ Positive ☐ Negative

What physical, cognitive, and/or emotional goals do you have for this participant?

Is there any additional information EquiCenter should know about this individual's medical condition? _____

Special precautions/needs: _____



Participant's Name: _____

Please note that the following conditions may suggest *precautions and contraindications to therapeutic horseback riding*.

Therefore, when completing these forms, please note whether the conditions are present and to what degree. Attach any supplementary information as necessary; additional forms may be required.

Orthopedic

- ☐ Atlantoaxial instability
 - include neurologic symptoms
- ☐ Coxa Arthrosis
- ☐ Cranial Deficits
- ☐ Heterotopic Ossification/Myositis Ossificans
- ☐ Joint subluxation/dislocation
- ☐ Osteoporosis
- ☐ Pathological Fractures
- ☐ Spinal fusion/fixation
 - ☐ Type?
- ☐ Spinal instabilities/abnormalities

Neurologic

- ☐ Hydrocephalus/Shunt
- ☐ Seizure
- ☐ Spinal Bifida/Chiari II Malformation
- ☐ Tethered Cord/Hydromelia

Other

- ☐ Age- under 4 years
- ☐ Indwelling Catheters/Medical Equipment
- ☐ Medications - ie, photosensitivity
- ☐ Poor Endurance
- ☐ Skin Breakdown

Medical

- ☐ Allergies
- ☐ Blood Pressure Control
- ☐ Cardiac Condition
- ☐ Exacerbations of Conditions
- ☐ Hemophilia
- ☐ Medical Instability
- ☐ Migraines
- ☐ PVD
- ☐ Respiratory Compromise
- ☐ Recent Surgeries
- ☐ Weight Control Disorders

Psychological

- ☐ Animal Abuse
- ☐ Physical/Sexual/Emotional
- ☐ Dangerous to self or others
 - ☐ Fire Settings
 - ☐ Substance Abuse
 - ☐ Thought Control Disorders



Participant's Name: _____

Height: _____ Weight: _____

Please check any system/area where the individual has experienced difficulties in the past, including surgeries. Additional comments are welcome.

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

After a careful review of their medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why the above participant cannot participate in supervised equestrian activities.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

Phone: _____ Address: _____

License/UPIN Number: _____