EquiCenter

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): _____

_____

<u>May require additional paperwork:</u>

Scoliosis ☐ Yes ☐ No Type _____ Degree _____

Back Rod ☐ Yes ☐ No Placement _____

Participant's Name: _____

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 further information that EquiCenter should know regarding this individual's medical condition?_____

_____

_____

_____

Special precautions/needs: _____

_____

Participant's Name: _____

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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

others

Other

- ☐ Age- under 4 years

Disorders

- ☐ 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
- ☐ Physica/Sexual/Emotional
- ☐ Dangerous to self or

- ☐ Fire Settings
- ☐ Substance Abuse
  - ☐ Thought Control

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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:_____