Miracles in Motion

Therapeutic Equestrian Center

PREMIER ACCREDITED CENTER
PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT

Date:

Dear Health Care Provider:

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

(Participant's Name)

In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree by circling the condition and describing below. Please complete the Participant Medical History & Physician Statement, as well.

Orthopedic

Antoaxial Instability – include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint Subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

PVD

Neurological

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/ Tethered Coed/Hydromyelia
Weight Control Disorder
Blood Pressure Control

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Dangerous to Self or Other
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical
Instability
Migraines

Recent Surgeries
Respiratory Compromise
Substance Abuse
Thought Control Disorders

Other

Age – Under 4 years
Indwelling Catheters/Medical Equipment Medications – e.g., Photosensitivity Poor Endurance
Skin Breakdown

_____
_____
_____
_____

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact Miracles in Motion via email or phone, as indicated below.

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

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Participant: DOB: Height
Weight: _____ Addr

Diagnosis: Date of Onset:

Past/Prospective Surgeries:

Medications:

Seizure Type: Controlled: Y N Date of Last Seizure:

Shunt Present: Y N Date of last revision:

Special Precautions/Needs:

Mobility: Independent Ambulation? Y N Assisted Ambulation? Y N Wheelchair? Y N

Braces/Assistive Devices:

For those with Down Syndrome: AtlantoDens Neurologic Symptoms of Atlantoaxial Instability: □ Present □ Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

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

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 Miracles in Motion Therapeutic Equestrian Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Miracles in Motion for ongoing evaluation to determine eligibility for participation.

Name/Title: MD DO NP PA Other: ____ Signature: Date: Address:

Phone: License/UPIN Number: