Dear Therapist, Health Professional, or Educator,

One of your clients/students has applied to receive therapeutic riding instruction at Dare to Dream Therapeutic Horsemanship Center 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 our instructors at the Dare to Dream office, 540-499-2010. Please return the completed forms to the Dare to Dream office, or mail them to Dare to Dream Therapeutic Horsemanship Center, 515 Wade Woods Lane, Monterey, VA 24465.

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

**Neurologic**

Hydrocephalus/shunt

Spina Bifida

Tethered Cord

Chiari II Malformation

Hydromyelia

Paralysis due to Spinal Cord Injury

Seizure Disorders

**Medical/Surgical**

Allergies Stroke (Cerebrovascular

Accident)

Cancer

Poor Endurance

Recent Surgery

Diabetes

Peripheral Vascular Disease

Varicose Veins

Hemophilia

Hypertension

Serious Heart Condition

**Secondary Concerns**

Behavior Problems (including a

history of violence or abuse

toward people or animals or

pyromania)

Bipolar disorder

Schizophrenia

Age under 2 years

Age 2-4 years

Acute exacerbation of chronic

disorder

Indwelling catheter

**PARTICIPANT’S MEDICAL HISTORY/ THERAPIST’S STATEMENT**

**(To be completed by Health or Educational Professional other than M.D.)**

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 Dare to Dream Therapeutic Horsemanship 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty/Licensing:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State/Federal License Number, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_