



Magic in Motion Medical History and Physician's Statement

Name: _____ Date of Birth: _____ Sex: M F

Parent/Guardian: _____

Address: _____ Phone #: _____

Diagnosis: _____ Date of Onset: _____

** For Persons with Down Syndrome**

Negative Cervical X-ray for Atlantoaxial Instability. X-ray date: _____

Negative for clinical Symptoms of Atlantoaxial Instability

Tetanus Shot: Yes No Date: _____ Height _____ Weight _____

Seizure type: _____ Controlled: _____ Date of Last Seizure: _____

Medications (type, dose, purpose): _____

Please indicate if the client has a history or any of the following secondary problems. If yes, please include complete information, including surgical history.

PROBLEM	YES	NO	COMMENTS
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses/Contacts?
Allergies			
Cardiac			
Circulatory			
Gastrointestinal			
Gastrostomy			
Pulmonary			
Asthma/COPD			
Neurological			
Hydrocephalus/Shunt			
Balance Impairment			
Sensory Loss			
Hypertonicity			
Urological			
Incontinence			
Indwelling Catheter			
Muscular			
Contractures			



PROBLEM	YES	NO	COMMENTS
Skeletal			
Spinal Column Injury			
Subluxed/dislocated joint			
Laminectomy			
Spinal Fusion			
Scoliosis – Type/Degree/Brace/X-ray			
Kyphosis/Lordosis – Type/Degree			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Fractures – Location/Healed?			
Other			

Mobility Status

Ambulatory: Yes No

Assistive Device: Cane Crutches Walker

Wheelchair: Yes No

Prosthetics/Orthotics: Yes No Please specify: _____

Please indicate any special precautions: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. I have reviewed the listed precautions and contraindications. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementing of an effective equestrian program.

Physician Name (please print): _____

Physician Signature: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____

Date: _____



Information for Physician

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 degrees.

Orthopedic

Spinal Fusion
Spinal Instabilities/Abnormalities
Atlantoaxial Instabilities
Scoliosis
Kyphosis
Lordosis
Hip Subluxation and Dislocation
Osteoporosis
Pathologic Fractures
Coxas Arthrosis
Osteogenesis Ossification
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
Cancer
Poor Endurance
Recent Surgery
Diabetes
Peripheral Vascular Disease
Varicose Veins
Hemophilia
Hypertension
Serious Heart condition
Stroke (Cerebrovascular Accident)

Secondary Concerns

Behavior Problems
Age under two years

Age two to four years
Acute exacerbations of chronic disorder
Indwelling catheter