



**P.O. Box 671828
Chugiak, AK 99567
Message Phone: (907) 929-7876
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RIDER MEDICAL HISTORY and PHYSICIAN'S EVALUATION

A qualified physician MUST complete this form if client is to participate in the horseback riding program.

Rider's Name: _____ - DOB: _____

Age: _____ Rider's Height: _____ Rider's Weight: _____ Male Female

Diagnosis: _____ Date of Onset: _____

Medications: _____

Tetanus: Yes No Date of Last Tetanus: _____

Seizure Type: _____ Controlled: Yes No Date of Last Seizure: _____

Shunt Present: Yes No Date of Last Revision: _____

If Down Syndrome, Atlanto-Axial Subluxation? Yes No
Cervical X-Ray for Subluxation? Positive Negative X-Ray Date: _____
Neurological Symptoms of AtlantoAxial Instability: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation Assisted Ambulation Wheelchair
Braces/Assistive Devices _____

Please indicate current or past difficulties in any of the following area, by checking YES or No.

<u>Concern</u>	<u>YES</u>	<u>NO</u>	<u>If YES, please describe</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Auditory Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tactile Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	_____
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary/Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immunity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural Hypotension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional/Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

The following conditions may suggest precautions and contraindications to therapeutic horseback riding. Please note whether these conditions are present and to what degree.

<u>Orthopedic Conditions</u>	<u>YES</u>	<u>NO</u>	<u>If YES, please describe</u>
Atlantoaxial Instability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coxa Arthrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cranial Deficits	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heterotopic Ossification/Myositis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Subluxation/dislocation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pathological Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Fusion/Fixation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinal Instability/Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spondylolistesis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kyphosis/Lordosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laminectomy/Fusion	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Neurological Conditions</u>			
Hyrocephalus/Shunt	<input type="checkbox"/>	<input type="checkbox"/>	_____
SpinaBifida/Chiari II Malformation/ Tethered Cord/Hydromyelia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other

Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indwelling Catheters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medications (i.e. photosensitivity)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensory Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor Endurance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Animal Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical/Sexual/Emotion Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure Control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dangerous to self or others	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exacerbations of medical conditionsl	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical Instability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
PVD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Compromise	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thought Control Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Control Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that **STRIDE** 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 profession (e.g. PT, OT Speech Therapist, Psychologist, etc.) in the implementation of an effective equestrian program.

Name/Title (please print): _____ MD DO NO PA Other _____

Address: _____

City: _____

Phone: () _____ License/UPIN Number: _____

Physician's Signature: _____ Date: _____

Please return this completed and signed form to:

STRIDE
Southcentral Therapeutic Riding, Inc.

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