Participant's Medical History & Physician's Statement

Participant: _____

DOB: _____ Height: _____ Weight: _____

Address: _____City: _____
ST: _____ Zip_____

Primary Diagnosis: _____Date of Onset: _____
Secondary Diagnosis: _____Date of Onset: _____
Other Diagnosis: _____Date of Onset: _____
Medications: _____
_____
Seizure Type: _____ Controlled: Y / N Date of Last Seizure: _____
Shunt Present: Y / N Date of last revision: _____
Past/Prospective Surgeries: _____
Special Precautions/Needs: _____
Mobility: Independent Ambulation Y / N Assisted Ambulation Y / N Please Specify: _____

For those with Down Syndrome: Atlanto-Dens Interval X-rays, date(s): _____ Result: + or -
Neurologic Symptoms of Atlanto-Axial Instability: _____
As thoroughly as possible, p*lease indicate below current or past difficulties/symptoms in the following systems/areas, including surgeries or assistive braces or devices:*

Systems/areas	**Y**	**N**	**Comments**
Allergies			
Auditory			
Visual			
Speech			
Tactile Sensation			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Balance			
Orthopedic			
Bowl/Bladder			
Cognitive			
Learning Disabilities			
Emotional/Psychological			
Psychological Evaluation completed w/ date			
Behavior			
Pain			
Other			

MEDICAL HISTORY IS 2 PAGES AND DOCTOR'S SIGNATURE IS REQUIRED ON THE BACK OF THIS PAGE ———>

Participant's Medical History & Physician's Statement

Client's Name: _____

In order to safely provide this service, OTR requests that you please note that the following conditions may suggest precautions and contraindication to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic
Atlantoaxial Instability-include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Spinal Joint Instability/Abnormalities
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Instability/Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizures
Spina Bifida/hiari II malformation/Tethered Cord/Hydromyelia

Atlantoaxial Instability (AAI) (see next form)

Other
Indwelling Catheters/Medical Equipment
Medications- ie. Photosensitivity
Poor Endurance
Skin breakdown
Reaction to cold or hot weather

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Substance Abuse
Thought Control Disorders
Weight Control

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine assisted activities. I understand that OTR will weigh the medical information indicated above against any existing precautions and/or contraindications before accepting this client for equine assisted therapy and/or occupational or physical therapy. Therefore, I refer this person to OTR for evaluation to determine eligibility for participation with ongoing treatment as described in therapy evaluation.

Name/Title: _____ MD / DO / NP / PA Other _____
Address: _____ City _____ ST _____ Zip _____
Phone: ( )_____ License/UPIN Number: _____
Doctor's Signature: _____ Date: _____
Parent/guardian/caregiver Signature: _____ Date: _____

Please return original forms signed to address listed below by mail, you may also scan and email it to us at the email below and bring the original on the date of evaluation or next session. This form MUST be returned before initial evaluations and also yearly to be in compliance to participate in all OTR programs, activities and therapies. Without it no services can be provided.

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