EquineAbility Therapeutic Riding Centre

Rider Medical Form

Date_____
(YYYY, MM, DD)

Rider's Name_____
(Last Name) (First Name) (Initial)

Date of Birth _____
(YYYY, MM, DD)

Sex: M ☐ F ☐ Age_____ Height _____ Weight_____(lbs/kgs)

Primary Diagnosis:_____

Medical History (including surgeries)_____

Current Medications_____

Contraindications to Horseback Riding: Does the rider have any of the following?

Contraindication	**Yes**	**No**
Spinal Fusion or internal spinal fusion devices	☐	☐
Presence of Herrington rod	☐	☐
Scoliosis of 30 degrees or greater	☐	☐
Spinal cord paralysis higher than mid thoracic	☐	☐
Acute arthritis (rheumatoid)	☐	☐
Atlantoaxial instability (Must be "No" to participate – see page 4)	☐	☐
Severe Osteoporosis	☐	☐
Spondylothesis	☐	☐
Prolapsed intervertebral disc	☐	☐
Sublixation or dislocation of hip	☐	☐
Haemophilia	☐	☐

Precautions To Horseback Riding: Does the rider have any of the following

Precautions	Yes	No
Seizures?	☐	☐
If yes, Petite mal ☐ Grand mal ☐ Controlled ☐* Uncontrolled ☐ * For Grandmal - Controlled if no seizure within 6 months on medication or no seizure within a year without medication		
Open pressure sores or open wounds on weight-bearing surfaces	☐	☐
Indwelling catheter	☐	☐
Increased blood pressure	☐	☐
Experiences with vertigo or dizziness	☐	☐
Heart condition	☐	☐
Allergies	☐	☐
Please specify:		
Epipen?	☐	☐
Is there any other reason which may preclude the rider from participation in a therapeutic riding program? (Please elaborate)		

Motor/Sensory Function

Ambulation (include aids and distance) _____

Balance	Unable	Poor	Fair	Excellent
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Tone		**Low**	**Normal**	**High**
Upper extremity right		☐	☐	☐
Upper extremity left		☐	☐	☐
Lower extremity right		☐	☐	☐
Lower extremity left		☐	☐	☐

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Motor/Sensory Function	Yes	No
Contractures or malformities? *If yes, provide details*	☐	☐
Joint subluxation or dislocation? *If yes, provide details*	☐	☐
Prosthetics/Orthotics? *If yes, provide details*	☐	☐
Vision issues? *If yes, provide details*	☐	☐
Hearing issues? *If yes, provide details*	☐	☐
Behaviour issues? *If yes, provide details*	☐	☐

Communication	Poor	Fair	Good
Ability to comprehend	☐	☐	☐
Verbal skills	☐	☐	☐
Other ways to communicate?			

Considering your patient's medical history, how often do you feel this medical form should be filled out again? 1 year ☐ 2 years ☐ 3 years ☐ 5 years ☐

The undersigned hereby acknowledges that _____ is medically able to participate in the horse riding program offered by EquineAbility Therapeutic Riding Centre. I concur with the referral of the patient to a volunteer physiotherapist for evaluation of his/her abilities and/or limitations, as deemed necessary.

Doctor's Name_____Signature_____
(Please Print)

Address_____Phone_____

_____

Atlantoaxial Dislocation Examination
(Must be completed for riders with Down Syndrome)

Date_____
(YYYY, MM, DD)

This is to certify that _____, who has Down Syndrome, has had the requested x-rays taken (full extension and flexion of the neck) to determine a pathological displacement of C1 and C2.

Date of X-ray_____
(YYYY, MM, DD)

Results: Positive ☐

Negative ☐

Physician's Name_____Signature_____

Address_____
(or stamp)
_____

Phone _____

NOTE: Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a **negative** diagnostic x-ray for atlantoaxial instability. This form must be updated every two (2) years. Please attach the copy of the x-ray results with submission of this form.