EQUICENTER
WILLIAM & MILDRED LEVINE RANCH

Medical History & Physician Statement
(Must be completed by physician.)

Dear Physician,

Your patient _____ is interested in participating in supervised equestrian activities.
(Participant's Name)

In order to safely provide this service, EquiCenter, Inc. requires that you complete the attached Medical History and Physicians Statement Form. Completed forms can be emailed to lalberts@equicenterny.org or faxed to 585-684-7863.

Participant's Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

_____

Medications: _____

_____

Seizure Type: _____ ☐ Controlled Date of Last Seizure: _____

Shunt Present: ☐ Yes ☐ No Date of Last Revision: _____

Date of Last Hip Radiograph: _____ Result (please describe): _____

Special precautions/needs: _____

Mobility:

- Independent Ambulation: ☐ Yes ☐ No
- Assisted Ambulation: ☐ Yes ☐ No
- Wheelchair: ☐ Yes ☐ No
- Braces/Assistive Devices: ☐ Yes ☐ No

For those with Down Syndrome:

- Neurologic symptoms of AtlantoAxial Instability: ☐ Present ☐ Absent
- Atlanto Dens X-Rays Date: _____ Result: ☐ Positive ☐ Negative

What physical, cognitive, and/or emotional goals do you have for this participant?

_____

_____

Is there any further informaton that you think EquiCenter should know regarding the medical condition of this individual?

_____

_____

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Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree. Attach any additional information as necessary.

Orthopedic

____ Atlantoaxial instability-include neurologic symptoms
____ Coxa Arthrosis
____ Cranial Defects
____ Heterotropic ossification/ Myositis Ossificans
____ Joint subluxation/dislocation
____ Osteoporosis
____ Pathologic fractures
____ Spinal fusion/fixation
____ Spinal instabilities/abnormalities

Medical/Psychological

____ Allergies
____ Animal abuse
____ Cardiac Condition
____ Physical/ Sexual/ Emotional Abuse
____ Blood pressure control
____ Dangerous to self or others
____ Exacerbations of medical conditions
____ Fire Settings
____ Hemophilia
____ Medical Instability
____ Migraines
____ PVD
____ Respiratory Compromise
____ Recent surgeries
____ Substance abuse
____ Thought control disorder
____ Varicose veins
____ Weight control disorder

Neurologic

____ Hydrocephalus/shunt
____ Seizure
____ Spina Bifida
____ Chiari II malformation
____ Tethered cord
____ Hydromyelia

Other

____ Age-under 4 years
____ Indwelling catheters
____ Medications
i.e. photosensitivities
____ Poor endurance
____ Skin breakdown

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Check any system/arena where the individual is experiencing or has experienced difficulties in the past, including surgeries. Additional comments are welcome.

	System/Arena	Comments
	Auditory	
	Visual	
	Tactile Sensation	
	Speech	
	Cardiac	
	Circulatory	
	Integumentary/Skin	
	Immunity	
	Pulmonary	
	Neurologic	
	Muscular	
	Balance	
	Orthopedic	
	Allergies	
	Learning Disability	
	Cognitive	
	Emotional/Psychological	
	Pain	
	Other	

After careful review of their medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why _____ cannot participate in supervised equestrian activities.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

Phone: _____

Address: _____

License/UPIN Number: _____

Thank you for your assistance. If you have any questions or concerns regarding this individual's participation in therapeutic equestrian activities, please contact us at 585-624-7777.