



# The Carriage Barn Equestrian Center Therapeutic Riding Program

6 Sarah's Way  
Newton, NH 03858  
www.carriage-barn.com

Phone: 603-378-0140  
Fax: 603-974-0779  
carriage-barn@comcast.net

A 501(c)3 Not-For-Profit Organization

## Participant's Medical History and Physician's Statement

Date: \_\_\_\_\_

Dear Physician:

Your patient, \_\_\_\_\_, is interested in participating in supervised equestrian activities at The Carriage Barn Equestrian Center, a Member Operating Center of NARHA (North American Riding for the Handicapped Association).

In order to safely provide this service, we request that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

### ORTHOPEDIC

AtlantoAxial Instability – include neurological symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint Subluxation/Dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

### NEUROLOGIC

Hydrocephalus/Shunt  
Seizure  
Spina Bifida/Chiari II Malformation/Tethered  
Cord/Hydromyelia

### OTHER

Age – under 4 years  
Indwelling Catheters  
Medications – i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

### MEDICAL/PSYCHOLOGICAL

Allergies  
Animal Abuse  
Physical/Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Setting  
Heart Conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you very much for your assistance. Please include any additional evaluations that would be helpful in determining the patient's appropriateness for this program. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact The Carriage Barn Therapeutic Program.

Sincerely, \_\_\_\_\_

## Participant's Medical History and Physician's Statement

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries: \_\_\_\_\_

Medications: \_\_\_\_\_

Seizure Type: \_\_\_\_\_ Controlled: Y N Date of Last Seizure: \_\_\_\_\_

Shunt Present: Y N Date of last revision: \_\_\_\_\_

Special Precautions/Needs: \_\_\_\_\_

Mobility: Independent Ambulation Y N                      Assisted Ambulation Y N                      Wheelchair Y N

Braces/Assistive Devices: \_\_\_\_\_

For those with Down Syndrome: AtlantoDens Interval X-rays, Date: \_\_\_\_\_ Result: + -

Neurological Symptoms of AtlantoAxial Instability: \_\_\_\_\_

***Please indicate current or past difficulties in the following systems / areas, including surgeries:***

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

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. 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 (i.e.: PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name / Title: \_\_\_\_\_ MD DO NP PA Other \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ License/UPIN # \_\_\_\_\_