

# Reins From Above Therapeutic Riding Center, Inc.

86 Polenta Road  
Smithfield, NC 27577  
Phone: 919-938-1556

Website: [www.reinsfromabove.org](http://www.reinsfromabove.org)

## PARTICIPANT'S MEDICAL HISTORY/ THERAPIST'S STATEMENT (To be completed by Health or Educational Professional other than M.D.)

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

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Name of Parent/Guardian/Adult Caregiver, if any: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Current Therapy (Last treatment, date, remarks): \_\_\_\_\_

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

Please indicate if the client/student has a problem and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

Areas	Yes	No	Comments
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disabilities			
Mental Impairment			
Psychological Impairment			
Other			

Mobility: Independent Ambulation ? Yes ? No; Crutches ? Yes ? No; Braces ? Yes ? No Wheelchair ? Yes ? No Please indicate any special precautions \_\_\_\_\_

Name of Health/Education Professional: \_\_\_\_\_ Specialty/Licensing: \_\_\_\_\_

## **PARTICIPANT'S MEDICAL HISTORY AND THERAPIST'S STATEMENT**

Participant's Name: \_\_\_\_\_

Physical Function Assessment(mobility skills, range of motion, etc.) \_\_\_\_\_

\_\_\_\_\_

Psycho/Social Function (i.e. emotional/mental health, behavioral issues, support systems, etc.) \_\_\_\_\_

\_\_\_\_\_

Concerns/potential safety issues in a farm or therapeutic riding setting? \_\_\_\_\_

\_\_\_\_\_

Therapeutic/Educational Goals? Include goals that might be addressed within the framework of a therapeutic riding lesson: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **THERAPIST'S or EDUCATOR'S STATEMENT**

Unless otherwise noted in this form, to my knowledge there is no reason why this person cannot participate in supervised equestrian and outdoor activities. I understand that Reins From Above Therapeutic Riding Center may contact me to discuss this information and will weigh the medical information above against the existing precautions and contraindications.

Therapist Name (Please Print) \_\_\_\_\_

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Specialty/Licensing: \_\_\_\_\_

State/Federal License Number, if applicable: \_\_\_\_\_

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Dear Therapist, Health Professional, or Educator,

One of your clients/students has applied to receive therapeutic riding instruction at Reins From Above Therapeutic Riding Center, Inc. this year. Please fill out the attached form to the best of your ability and answer all of those questions which fall within your area of expertise or about which you have some pertinent information. Your input will help us to decide whether this person will benefit from therapeutic riding and/or establish goals for a therapeutic riding plan. If you have any questions about this form, please call one of our instructors at 919-938-1556.

## Information for Therapist

The following conditions, if present, may represent precautions or contraindications to therapeutic horseback riding. Therefore when completing this form, please note whether these conditions are present, and to what degree.

<b>Orthopedic</b> Spinal Fusion Spinal Instabilities/Abnormalities Atlantoaxial Instabilities Scoliosis Kyphosis Lordosis Hip Subluxation and Dislocation Osteoporosis Pathologic Fractures Coxas Arthrosis Heterotopic Ossification Osteogenesis Imperfecta Cranial Deficits Spinal Orthoses Internal Spinal Stabilization Devices	<b>Medical/Surgical</b> Allergies Cancer Poor Endurance Recent Surgery Diabetes Peripheral Vascular Disease Varicose Veins Hemophilia Hypertension Serious Heart Condition Stroke (Cerebrovascular Accident)
<b>Neurologic</b> Hydrocephalus/shunt Spina Bifida Tethered Cord Chiari II Malformation Hydromyelia Paralysis due to Spinal Cord Injury Seizure Disorders	<b>Secondary Concerns</b> Behavior Problems Age under 2 years Age 2-4 years Acute exacerbation of chronic disorder Indwelling catheter