Stable Hands

Hearts, Hands and Horses,.....Building Dreams, Changing Lives

PATH INTERNATIONAL

Professional Association of Therapeutic Horsemanship International

Participant's Medical History & Physician's Statement

Participant: _____ D.O.B.: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ ICD10 _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Yes No Date of Last Seizure: _____

Shunt/Pacemaker or implanted device present: Yes No Type: _____

Special Precautions/Needs: _____

_____

Mobility: Ambulates independently With walker or cane Uses wheelchair

Prosthesis/Assistive Devices: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

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

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 neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myosistis 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

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 Disorder

OTHER

Age – under 4 yrs
Indwelling catheters
Photosensitivity
Poor Endurance
Skin Breakdown

Veteran Name:_____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that the PATH Intl. Center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. Center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other

Signature: _____ Date:

Address:

Phone: (____) _____ License/UPIN Number: _____