Miracles in Motion - Medical Form (2 pages)

Name:____Date of Birth:___________Sex:___

Parent/Guardian:____

Address:____Height:_______Weight:________

Diagnosis:____Date of Onset:_____________

***FOR PERSONS WITH DOWN SYNDROME:*
Cervical X-ray for Atlantoaxial Instability: Positive:__________Negative:__________X-ray Date:__________
As of the last exam on ________(date), does the patient have any symptoms of Atlantoaxial Instability?: Yes No
Comments:____
MEDICATIONS (Type, Purpose, Dose):______________________________________

____

SEIZURE TYPE:__________________Controlled______________Date of Last Seizure__________

Please indicate if the client has a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information, including surgical history, pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
Auditory Impairment			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			Glasses/Contacts:
Allergies			Type of Reaction:
Cardiac			
Circulatory			
Gastrointestinal			
Gastrostomy			
Pulmonary			
Asthma/COPD			
Neurological			
Hydrocephalus/Shunt			
Balance Impairment			
Sensory Loss			
Hypertonicity			
Hypotonicity			
Urological			
Incontinence			
Indwelling Catheter			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing or Dislocating Joints			
Laminectomy			
Spinal Fusion			
Scoliosis-Degree/Type/			
Brace/Last Xray			
Kyphosis/Lordosis			
Degree/Type			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Fractures			Location/Date Healed?
Other			
Surgeries			Details/Date:

Miracles in Motion - Medical Form – Continued

MOBILITY STATUS

Ambulatory? ☐ Yes ☐ No

Assistive Device? ☐ cane ☐ crutches ☐ walker

Prosthetics/Orthotics: ☐ Yes ☐ No If yes, please specify____

Please indicate special precautions:____

____

IN MY OPINION THE INDIVIDUAL NAMED ABOVE CAN PARTICIPATE IN SUPERVISED MOUNTED EQUESTRIAN ACTIVITIES. I HAVE REVIEWED THE LISTED PRECAUTIONS AND CONTRAINDICATIONS AND ANY DESCRIPTIVE MATERIALS ENCLOSED. THIS FORM IS VALID FOR A PERIOD OF ONE YEAR FROM THE DATE SIGNED.

Physician's Signature:_______________________________________Date:________________

Due to our accreditation guidelines, we accept only signatures of MD's or DO's.

Physician's Name (Please Print):____

Physician's Address:____

Telephone Number:____

INFORMATION FOR PHYSICIANS

Precautions & Contraindications to Therapeutic Riding

PRECAUTIONS

Hip subluxation/dislocation

Osteoporosis

Hydrocephalus/Shunt

Seizure disorders

CONTRAINDICATIONS

Osteogenesis Imperfecta

Atlantoaxial dislocation condition

Total hip arthroplasty

Spinal fusion

Spinal instability

Spinal cord injury above T12

Scoliosis > 30_