

SHADY HOLLOW ASSISTED RIDING MEDICAL HISTORY FORM



959 E Main St
Birdsboro, Pa 19508

610-582-4050
michele@hugahorse.com

Name: _____ DOB: ___/___/___
Age: ___ Sex: ___ Height: ___ Weight: ___ Pulse: ___ B.P.: ___

Diagnosis: _____
Cause: _____
Medications (Type, Purpose, Dose): _____

If Downs Syndrome, Atlanto-Axial Subluxation? Yes ___ No ___
Cervical X-Ray for Atlanto-Axial Subluxation: Positive ___ Negative ___ X-Ray Date ___/___/___

Please indicate any medical problems not indicated on back: _____

Please indicate special precautions: _____

Mobility Status:

Ambulatory? Yes ___ No ___
If NO, describe: _____

Prosthetics/Orthotics:

Type: _____ Purpose: _____
Type: _____ Purpose: _____

Please describe any other additional information that might help us to work with this students:

Physician's Name (please print): _____
Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

Please indicate if the client has or had a history of the following secondary problems by checking yes or no in the form on the back of this page. If **YES**, please include complete information pertaining to the problem.

Thank you for your time!

Problem	Yes	No	If YES, history describe
Auditory Impairment			
Learning Impairment			
Mental Impairment			
Psychological Impairment			
Speech Impairment			
Visual Impairment			
Allergies			
Cardiac			
Circulatory			
PVD			
Postural Hypotension			
Hemophilia			
Pulmonary			
Asthma/COPD			
Neurological			
Seizures			
Controlled			
Problem	Yes	No	If YES, history/describe
Last Seizure Date			
Hydrocephalus			
Shunt			
Sensory Loss			
Pain			
Muscular			
Contractures			
Skeletal			
Spinal Column Injury			
Subluxing Joints			
Dislocating Joints			
Laminectomy/Fusion			
Scoliosis			
Degree / Type			
Brace			
Last X-Ray			
Kyphosis/Lordosis			
Degree/Type			
Spondylolisthesis			
Spinal Abnormality			
Osteoporosis			
Heterptrophic Ossification			
Joint Disease			
Cranial Defects			
Fractures			
Others			