



**Therapeutic Rider/ Driver Medical Form**

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Date \_\_\_\_\_

(YYYY, MM, DD)

Participant's

Name \_\_\_\_\_

(Last Name)

(First Name)

(Initial)

Date of Birth \_\_\_\_\_

(YYYY, MM, DD)

Sex: M  F  Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ (lbs/kgs)

Primary Diagnosis: \_\_\_\_\_

Medical History (including surgeries) \_\_\_\_\_

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

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**Contraindications to Horseback Riding:** Does the participant have any of the following?

Contraindication	Yes	No
Spinal Fusion or internal spinal fusion devices	<input type="checkbox"/>	<input type="checkbox"/>
Presence of Herrington rod	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis of 30 degrees or greater	<input type="checkbox"/>	<input type="checkbox"/>
Spinal cord paralysis higher than mid thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Acute arthritis (rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>
Atlantoaxial instability (Must be "No" to participate – see page 4)	<input type="checkbox"/>	<input type="checkbox"/>
Severe Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>
Prolapsed intervertebral disc	<input type="checkbox"/>	<input type="checkbox"/>
Subluxation or dislocation of hip	<input type="checkbox"/>	<input type="checkbox"/>
Haemophilia	<input type="checkbox"/>	<input type="checkbox"/>



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**Precautions To Horseback Riding:** Does the participant have any of the following

Precautions	Yes	No
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Petite mal <input type="checkbox"/>		
Grand mal <input type="checkbox"/> Controlled <input type="checkbox"/> * Uncontrolled <input type="checkbox"/>		
* For Grandmal - Controlled if no seizure within 6 months on medication or no seizure within a year without medication		
Open pressure sores or open wounds on weight-bearing surfaces	<input type="checkbox"/>	<input type="checkbox"/>
Indwelling catheter	<input type="checkbox"/>	<input type="checkbox"/>
Increased blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Experiences with vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Please specify:		
Epipen?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other reason which may preclude the individual from participation in a therapeutic riding/ driving program? (Please elaborate)		

**Motor/Sensory Function**

Ambulation (include aids and distance) \_\_\_\_\_

Balance	Unable	Poor	Fair	Excellent
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tone	Low	Normal	High	
Upper extremity right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Upper extremity left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lower extremity right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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Lower extremity left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Motor/Sensory Function</b>		<b>Yes</b>	<b>No</b>
Contractures or malformities? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>
Joint subluxation or dislocation? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>
Prosthetics/Orthotics? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>
Vision issues? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>
Hearing issues? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>
Behaviour issues? <i>If yes, provide details</i>		<input type="checkbox"/>	<input type="checkbox"/>

<b>Communication</b>	<b>Poor</b>	<b>Fair</b>	<b>Good</b>
Ability to comprehend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other ways to communicate?			

Considering your patient's medical history, how often do you feel this medical form should be filled out again? <span style="margin-left: 20px;">1 year <input type="checkbox"/></span> <span style="margin-left: 40px;">2 years <input type="checkbox"/></span> <span style="margin-left: 40px;">3 years <input type="checkbox"/></span> <span style="margin-left: 40px;">5 years <input type="checkbox"/></span>
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The undersigned hereby acknowledges that \_\_\_\_\_ is medically able to participate in the horse riding/ driving program offered by Windy Acres Stable. I concur with the referral of the patient to a volunteer physiotherapist for evaluation of his/her abilities and/or limitations, as deemed necessary.

Doctor's Name \_\_\_\_\_ Signature \_\_\_\_\_  
(Please Print)

Address \_\_\_\_\_ Phone \_\_\_\_\_



**Atlantoaxial Dislocation Examination**

(Must be completed for participants with Down Syndrome)

Date \_\_\_\_\_  
(YYYY, MM, DD)

This is to certify that \_\_\_\_\_, who has Down Syndrome, has had the requested x-rays taken (full extension and flexion of the neck) to determine a pathological displacement of C1 and C2.

Date of X-ray \_\_\_\_\_  
(YYYY, MM, DD)

Results:      Positive

                  Negative

Physician's Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_  
(or stamp)

\_\_\_\_\_

Phone \_\_\_\_\_

**NOTE:** Due to the nature of this activity, persons diagnosed with Down Syndrome cannot be accepted for riding/ driving instruction without proof of a **negative** diagnostic x-ray for atlantoaxial instability. This form must be updated every two (2) years. Please attach the copy of the x-ray results with submission of this form.