Hope Springs Equestrian Therapy, Inc.
P. O. Box 156, Chester Springs, PA 19425
(610) 827-0931

**SUMMARY OF RIDER'S MEDICAL HISTORY**
***(TO BE COMPLETED BY RIDER'S ATTENDING PHYSICIAN)***

Name of Rider: _____ Birth Date:_____
Address: _____ Sex: _____
_____ Height: _____
Telephone: _____ Weight: _____

Check whichever of the following applies:

Physically disabled: Yes: _____ No: _____
Mentally disabled: Yes: _____ No: _____
Learning disabled: Yes: _____ No: _____
Emotional illness: Yes: _____ No: _____

Diagnosis: _____
_____
Date of onset of illness or disability: _____
Cause: _____
Limbs affected: _____
If spinal cord involvement, what vertebral level? _____
If Down's Syndrome, please confirm x-rays show no atlanto-axial subluxation: _____

MOBILITY:
Can Rider ambulate? Yes: _____ No: _____
With assistance: independent: _____ minimal: _____ maximum: _____
With aids: cane: _____ crutches: _____ walker: _____

Is Rider a suitable candidate for equine-facilitated therapy? _____
Precautions: _____
_____
Additional comments: _____
_____
_____
Physician's signature: _____
Printed name: _____
Phone Number: _____
Date signed: _____
Date of last examination: _____

**Please also complete the Medical History Chart - Below**

## MEDICAL HISTORY CHART

Please indicate if Rider has any of the following secondary medical problems by checking "yes" or "no." If "yes," please include complete information pertaining to the problem.

| Condition/Problem | Yes | No | If yes, please describe |
|---|---|---|---|
| Allergies | | | |
| Visual | | | |
| Hearing | | | |
| Speech | | | |
| Cardiac | | | |
| Circulatory | | | |
| Pulmonary | | | |
| Metabolic/G.I./G.U. | | | |
| Bladder/Bowel Control | | | |
| Skin and Soft Tissue | | | |
| Surgeries (provide dates) | | | |
| Pain | | | |
| Seizures<br>Controlled?<br>Type?<br>Date of last seizure: | | | |
| Muscular/Contractures | | | |
| Skeletal (i.e., subluxing hips, scoliosis, kyphosis, lordosis) | | | |
| Fractures (indicate location, date and whether healed) | | | |
| Contagious condition(s) | | | |
| Other or Special Precautions | | | |

Please include any additional information which might help us work with this Rider:

_____

_____