A New Dawn Therapeutic Riding Program

1164 Blattdahl Road * Mohrsville, PA 19541 * 610-655-5271

MEDICAL HISTORY

Hippotherapy Clients – this form MUST be completed and signed by the client's physician
Therapeutic Riding Clients – this form can be completed and signed by the client's parent/guardian

Client's Name: _____ Age: _____

Date of Birth: _____ Height: _____ Weight: _____

Physical Disability? YES NO
Learning Disability? YES NO
Intellectual Disability? YES NO
Emotional Disability? YES NO

Estimate of Mental Ability: _____

Diagnosis: _____

Cause: _____ Onset: _____

Limbs Affected: _____

If Spinal Cord involvement, what vertebrae level: _____

If Down's Syndrome:

A. Lateral view roentgenograms of the upper cervical region in:
   1. Full Flexion: positive _____ negative _____ Date: _____
   2. Extension: positive _____ negative _____ Date: _____

B. Atlanto-axial instability or neurological disorder? YES NO

List all current prescribed medications: _____

_____

Please indicate if the client has any of the following secondary problems by checking yes or no. If you check yes, please provide detailed information.

PROBLEM	NO	YES	IF YES, please provide details
Visual			
Hearing			
Speech			
Cardiac			

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Blood Pressure: _____ Pulse: _____

PROBLEM	NO	YES	IF YES, please provide details
Pulmonary			
Circulatory			
Peripheral Vascular Disorder			
Hemophilia			
Metabolic/GI-GU			
Diabetes			
Bladder/Bowel Control			
Skin and Soft Tissue			
Pressure Sore			

Healed? YES NO Location: _____

PROBLEM	NO	YES	IF YES, please provide details
Pain			
Surgery			

Procedure: _____ Date: _____

PROBLEM	NO	YES	IF YES, please provide details
Neurological			
Sensory Loss			
Hydrocephalus			
Shunt			
Seizures			
Controlled			

Last Seizure Date and Type: _____

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PROBLEM	NO	YES	IF YES, please provide details
Musculature			
Contractures			
Skeletal			
Hip Subluxation			
Hip Dislocation			
Spinal Laminectomy			
Scoliosis			

Degree: _____ Location: _____ Last X-ray: _____

PROBLEM	NO	YES	IF YES, please provide details
Kyphosis, Lordosis			

Degree: _____ Type: _____ Last X-ray: _____

PROBLEM	NO	YES	IF YES, please provide details
Spondylosis			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossification			
Arthrodesis			
Fractures			

Healed: YES NO Location: _____

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Mobility Status

Can the client ambulate? YES NO

Assistance: Independent Minimal Moderate Maximal

One Person Assist Two Person Assist

Physical Aids: Canes Crutches Walker Rolling Walker

Orthotic/Braces (type): _____

Does the client use a wheelchair? YES NO If yes, type: _____

Can the client propel the wheelchair? YES NO

Physician's Signature: _____ Date: _____

Physician's Name: _____Phone: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____Phone: _____