



Therapeutic Horseback Riding Program
100 Let'er Buck Road Hailey, ID 83333 (208) 578-9111 fax (866)746-4883
lindsey@sagebrusharena.com www.sagebrushequine.org

PARTICIPANT HEALTH HISTORY

GENERAL INFORMATION

Participant: _____

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Gender:** M F

Employer/School: _____

Parent/Legal Guardian: _____

Referral Source: _____

Phone of referral source (if medical professional): _____

How did you hear about our program? _____

HEALTH HISTORY

Primary Diagnosis: _____

Date of Onset: _____

Secondary Diagnoses: _____

Date of Onset: _____

Current or past seizures? _____

Please elaborate type, frequency, and method of control: _____

Past surgeries? Please explain _____

Recent imaging studies (x-ray, MRI, CT scan, etc.) _____

Please indicate current or past considerations in the following areas (left-hand column gives area, right hand column gives examples of important information to include): *(Use separate sheet if necessary)*

		YES	NO	If YES please explain
Vision	Glasses/contacts			
Hearing	Hearing aids, implants			
Sensation	Over- or under-sensitive			
Communication	ASL, speech delays, gesture			
Heart	Surgeries, implants			
Breathing	Asthma, oxygen			
Digestion	Gastronomy tube			
Elimination	Catheters, colostomy, incontinence			
Circulation	Varicose veins, hemophilia, reduced circulation			
Emotional/Mental Health	Depression, anxiety			
Behavioral	Aggression, defiance			

Pain	Over- or under-sensitive, headaches, joint pain			
Bone/Joint	Spinal surgeries, fusions, implants, osteoporosis, arthritis			
Muscular	Weakness, high tone, low tone			
Neurologic	Seizures, ataxias, tremors			
Cognitive	Ability to follow 1 to multiple step instructions			
Allergies	Hay, dust, dander			

MEDICATIONS (include prescription and over-the-counter; name, dose and frequency)

The following conditions, if present, may represent **PRECAUTIONS** or **CONTRAINDICATIONS** to therapeutic horseback riding. Please note whether these conditions are present, and to what degree.

YES NO CONDITION

Orthopedic

- Spinal Fusion
- Spinal Instabilities/Abnormalities
- Atlantoaxial Instabilities
- Scoliosis
- Kyphosis
- Lordosis
- Hip Subluxation and Dislocation
- Osteoporosis
- Pathologic Fractures
- Coxas Arthrosis
- Heterotopic Ossification
- Osteogenesis Imperfecta
- Cranial Deficits
- Spinal Orthoses

- | <u>YES</u> | <u>NO</u> | <u>CONDITION</u> |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Internal Spinal Stabilization Devices
(such as Harrington Rods) |
| | | <u>Neurological</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocephalus/shunt |
| <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida |
| <input type="checkbox"/> | <input type="checkbox"/> | Tethered Cord |
| <input type="checkbox"/> | <input type="checkbox"/> | Chiari II Malformation |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydromyelia |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis due to Spinal Cord Injury (above T-9) |
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrolled Seizure Disorders |
| | | <u>Medical/Surgical</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to Grasses, Animals and Dust |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Endurance |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Vascular Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious Heart Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (Cerebrovascular Accident) |
| | | <u>Secondary Concerns</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Behavior Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Age less than two years |
| <input type="checkbox"/> | <input type="checkbox"/> | Age two – four years |
| <input type="checkbox"/> | <input type="checkbox"/> | Acute exacerbation of chronic disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Indwelling catheter |

If you checked **YES** to any of the above, please explain: _____

Describe the participant's abilities in the following areas:

PHYSICAL FUNCTION (include mobility skills such as use of assistive devices and transfers, orthotics worn and purpose)

PSYCHO/SOCIAL FUNCTION (include daily activities such as work or school - including grade completed, leisure interests, relationships, family structure, support system, companions and animals, fears)

GOALS (What would you like to accomplish through riding? Feel free to include other therapy goals and IEP objectives)

Signature: _____ **Date:** _____
(Participant/Parent/Guardian)

Please return this form to: Sagebrush Equine Training Center
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