

PATIENT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____

_____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Yes No Date of last seizure: _____

Date of last Tetanus Shot: _____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: Yes No Assisted Ambulation: Yes No

Wheelchair: Yes No

Braces/Assistive Devices: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

			Comments
Auditory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Visual	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Tactile Sensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Speech	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cardiac	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Circulatory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Integumentary/Skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Immunity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pulmonary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Neurologic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Muscular	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Balance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Orthopedic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Learning Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cognitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Emotional/Psychological	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

To my knowledge there is no reason why this person cannot participate in hippotherapy. However, I understand that the therapist will weigh the medical information above against the existing precautions and contraindications. I concur with the review of this person's abilities/limitations by a PT, OT, or SLP in the implementation of a hippotherapy treatment.

Name/Title: _____ MD DO NP PA Other _____

Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: () _____ License/UPIN Number: _____

Distinctive Speech & Language Services
Edmond, Oklahoma 73003-2477
Office (405) 514-3246 Fax (405) 285-9284

Date: _____

Dear Physician:

Your patient, _____, is: Interested in participating in hippotherapy; interested in continuing to participate in hippotherapy.

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to hippotherapy. Therefore, when completing this form, please note whether these conditions are present and to what degree.

	Degree	Orthopedic		Degree	Medical/Psychological
Yes No		Atlantoaxial Instability-Include neurologic symptoms	Yes No		Allergies
Yes No		Coxa Arthrosis	Yes No		Animal Abuse
Yes No		Crainal Deficits	Yes No		Physical/Sexual/Emotional Abuse
Yes No		Heterotopic Ossification / Myositis Ossificans	Yes No		Blood Pressure Control
Yes No		Joint subluxation/ dislocation	Yes No		Dangerous to self or others
Yes No		Osteoporosis	Yes No		Exacerbations of medical conditions
Yes No		Pathologic Fractures	Yes No		Fire Settings
Yes No		Spinal Fusion/Fixation	Yes No		Heart Conditions
Yes No		Spinal Instability/Abnormalities	Yes No		Hemophilia
		Neurologic	Yes No		Migraines
Yes No		Hydrocephalus/Shunt	Yes No		Peripheral Vascular Disease
Yes No		Seizure	Yes No		Respiratory Compromise
Yes No		Spina Bifida/Chiari II malformation / Tethered Cord/Hydromyelia	Yes No		Recent Surgeries
		Other	Yes No		Substance Abuse
Yes No		Age – under 2 years	Yes No		Thought Control Disorders
Yes No		Indwelling Catheters	Yes No		Weigh Control Disorder
Yes No		Medications – i.e. side effects of photosensitivity			
Yes No		Poor Endurance			
Yes No		Skin Breakdown			

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in hippotherapy, please feel free to contact the operating center at the address/telephone number indicated above.

PHOTO RELEASE

I consent to and authorize the use and reproduction by Distinctive Speech & Language Services, of any and all photographs and any other audio-visual material taken of _____, my _____, for promotional material, education activities, exhibitions or for any other use for the benefit of the program without payment or any other consideration. I understand and agree that these materials will be the property of DSLS and will not be returned. I hereby irrevocably authorize DSLS to exhibit, publish or distribute this photo for purposes of publicizing DSLS programs or for any other lawful purpose.

Signature

Print Name

Date