New Heights Therapy and Riding

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT
To be completed by physician

Participant's Name_____
Date of Birth_____
Parent(s)/
Guardians(s)_____
_____
Address_____
Home Phone_____
Height_____ Weight_____
Medications_____
Mobility: Independent Ambulation / Assisted Ambulation w/ crutches, walker, wheelchair
Medical Precautions:
Seizures: No / Yes If yes, Seizure Type _____ Date of Last Seizure_____ Now controlled? No /Yes
Shunt: No / Yes Date of Last Revision_____
Down Syndrome: Atlanto Dens Interval X-rays,
Date_____ Result + --
Any Neurological Symptoms of Atlanto Axial Instability?
_____

Primary Diagnoses/ Presenting Concern
_____

Please list current or past indications, special needs, surgeries in the following:

AREAS	YES	NO	COMMENTS
Visual			
Auditory			
Tactile Sensation			
Speech / Language			
Cognition/ Processing			
Learning/ Development			
Psychological/ Emotional/ Behavioral			
Muscular			
Balance			
Orthopedic – Note			

Scoliosis or hip subluxation or dislocation			
Neurologic			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/ Skin			
Immunity			
Pain			
Allergies			
Other			

To my knowledge, there is no reason this person cannot participate in supervised equestrian activities for OT, PT or SLP services by a licensed OT, PT or SLP as necessary in the implementation of an effective therapy program.

PHYSICIAN'S ORDERS:
____ OT ____PT ____SLP Recommended ____X/week for ____ weeks

Date_____ Name & Title (print)_____

Signature_____
Phone_____

Address_____ City_____
State____ Zip