2426 Narrow Gauge Rd
Reidsville, NC 27320
www.rollingridgeriding.org
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PATIENT MEDICAL HISTORY AND PHYSICIAN STATEMENT FORM

Name:_____DOB:_____
Diagnosis:_____Date of Onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type:_____controlled? ___Yes____No
Date of Last Seizure:_____
Shunt Present?_____Yes_____No Date of last revision:_____

Please relate current or past issues in each system, including surgeries:

			Comments
Auditory	Yes	No	_____
Visual	Yes	No	_____
Sensation	Yes	No	_____
Speech	Yes	No	_____
Cardiac	Yes	No	_____
Circulatory	Yes	No	_____
Integumentary/Skin	Yes	No	_____
Immune System	Yes	No	_____
Neurologic	Yes	No	_____
Pulmonary	Yes	No	_____
Balance	Yes	No	_____
Orthopedic	Yes	No	_____
Muscular	Yes	No	_____
Allergies	Yes	No	_____
Learning Disability	Yes	No	_____
Emotional/Psychological	Yes	No	_____
Pain	Yes	No	_____

NOTE: For riders with Down Syndrome, a neurologic exam is required

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Page 2 Medical Release Form
(Must be signed by the rider's physician)

To the best of my knowledge, there is no apparent reason why this person cannot participate in therapy based horseback riding/hippotherapy. However, I understand that the center 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 therapy based horseback riding/hippotherapy treatments.

Name/Title:_____

Signature:_____

Date:_____

Kathryn Davis, PT
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