Destiny's Ride Therapeutic Program Inc.
Program Location:114 Ostrander Rd Ghent, NY 12075
Mailing Address 406 Old Post Rd ~ Stop 24 Ghent, NY 12075
destinysridetherapeutic@gmail.com **(518) 610.4408**

Participant's Medical History and Physician's Statement

Dear Physician: ____________________ Your patient, ____________________is interested in participating in supervised equestrian activities. (participant's name) In order to safely provide this service, Destiny's Ride Therapeutic Program, Inc. requires that you complete the attached Medical History and Physicians Statement Form. Please note that the following conditions may suggest precautions and contraindication to therapeutic horseback riding. Therefore, when completing these forms, please note whether the conditions are present and to what degree.

Name: ____Date of Birth:____________ Ht:________ Wt.:________
Address:____
City________________________________ State:____________ Phone: ____________________________
Diagnosis: ____Date of Onset:__________________
Surgeries____
Medications:____
Seizure Type: _____________________________________ Controlled: Y N Date of last seizure_________
Shunt Present: Y N Date of last revision: ________________ Tetanus Shot: □ Yes □ No
Special Precautions/Needs:____
Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N
Braces/Assistive Devices: ____

*****For Persons with Down Syndrome:*** AtlantoDens Interval X-rays, date: ____________________ Result: pos / neg
Neurologic Symptoms of Atlantoaxial Instability: ____

What physical, cognitive and/or emotional goals do you have for this participant?
____
____

Is the any further information that you think Destiny's Ride Therapeutic Program, Inc. should know regarding the medical condition of this individual? ____
____

Please indicate current or past difficulties in the following systems/arena, including surgeries:	Yes	No	Comments
Auditory			
Visual			
Tactile			
Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional / Psychological			
Pain			
Other			

Patient's Name: ___________________________________

Please indicate whether these conditions are present and to what degree.

Please attach any necessary additional information.

Orthopedic

____Atlantoaxial instability-include neurologic symptoms
____Coxa Arthrosis
____ Cranial Defects
____ Heterotrophic ossification/ Myositis Ossificans
____ Joint subluxation/dislocation
____ Osteoporosis
____ Pathologic fractures
____ Spinal fusion/fixation
____ Spinal instabilities/abnormalities

Medical/Psychological

____ Allergies
____ Animal abuse
____ Physical/ Sexual/ Emotional Abuse
____ Blood pressure control
____ Dangerous to self or others
____ Exacerbations of medical conditions
____ Fire Settings
____ Heart conditions
____ Hemophilia
____ Medical Instability
____ Migraines
____ PVD
____ Respiratory Compromise
____ Recent surgeries
____ Substance abuse
____ Thought control disorder
____ Varicose veins
____ Weight control disorder

Neurologic

____ Hydrocephalus/shunt
____ Seizure
____ Spina Bifida
____ Chiari II malformation
____ Tethered cord
____ Hydromyelia

Other

____ Age-under 4 years
____ Indwelling catheters
____ Medications
i.e. photosensitivities
____Poor endurance
____ Skin breakdown

After careful review of (participant's name) ________________________ medical history and consideration of the risks of equestrian activities, to my knowledge, there is no reason why this person cannot participate in supervised equestrian activities.

Printed Name____ Title______________________

Signature____Date______________________Phone____________

Address____License/UPIN Number______________________

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact Jodie O'Connell-Ponkos 518-640-4408