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PHYSICIAN ASSESSMENT & HEALTH HISTORY

~~To be completed by physician~~

Client's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Height: _____ Weight: _____
Date of Last Tetanus shot: _____

Diagnosis:

Primary: _____ Date of Onset: _____
Secondary: _____ Date of Onset: _____
Other: _____ Date of Onset: _____

Past/Prospective Surgeries (include dates and reasons): _____

Medications: _____

Seizures: ___ No ___ Yes Type: _____ Date of last seizure: _____

Shunts, Implants: _____

Mobility: Independent Ambulation: ___ Yes ___ No Assisting Devices: _____

In order to safely provide this service, ManeGait requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II malformation/Tethered
Cord/Hydromyelia

Other

Indwelling Catheters/Medical Equipment
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Client's name: _____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply including surgeries.

Area	No	Yes	Degree/ Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

For those with Down Syndrome:

An Atlantoaxial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3. Date of X-Ray: _____ Results: _____
 Neurologic Symptoms of Atlantoaxial instability: _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that ManeGait Therapeutic Riding Center will weigh the medical information indicated above against any existing precautions and/or contraindication before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to ManeGait for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD, DO, NP, PA Other _____

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____