Participant's Medical History & Physician's Statement

Who should fill out this form: Please have the participants primary or treating physician fill out this form. If you are seeking services for HETRA's mental health programing, please have the psychiatrist or mental health practitioner fill out the form.

Your patient is interested in participating or continued participation in supervised equine-assisted services at our facility. In order to safely provide this service, our professionals request that you complete/update the Medical History and Physician's Statement Form as well as marking any potential Precautions or Contraindications to equine-assisted services.

Participant Name:____ Date of Birth______________________ Age___________

Height __________Weight____________ Name of Parent/Guardian ____

Parent/Guardian Phone: ________________________ Parent/Guardian Email:____

Diagnosis____ Date of Onset_____________________________

Past/FutureSurgeries____

Medical History

The list below may not preclude participation in HETRA programming but will allow the staff to create a treatment plan or curriculum that will help the participant achieve their desired goals.

Please indicate current or past areas of concern checking yes or no. If yes, please comment.

Area of Concern	Yes	No	Comments
Agitation/Anxiety			
Allergies (including medications)			
Auditory/Hearing			
Behavioral			
Cardiac			
Circulatory			
Digestion			
Elimination			
Hyperactivity			
Increased Sensitivities			
Memory Impairments			
Mood Changes			
Muscular			
Neurological			
Orthopedic			
Pain			
Problems Concentrating			
Pulmonary			
Sad/Depressed Mood			
Sensation			
Sleep/Appetite Changes			
Speech			
Social Withdrawal			
Thinking/Cognitive			
Visual			

For ALL participants with Down Syndrome: Due to the nature of Equine-Assisted Activities we require that ALL participants diagnosed with Down Syndrome must have an ANNUAL certification from their physician that a neurological and/or physical examination reveals no sign of AAI or decrease in neurological function:

1) ☐ Negative Cervical X-Ray for atlantoaxial instability- X-Ray date______________________
2) ☐ Negative for clinical symptoms of atlantoaxial instability

SEIZURE INFORMATION:

Has the participant experienced a Seizure in the Past? ☐ Yes ☐ No If yes please indicate seizure Type____________________

Are the seizures controlled? ☐ Yes ☐ No Date of last seizure________________

Current Medications:____

____

____

Is a Shunt Present: ☐ Yes ☐ No Date of Last Revision:______________ Tetanus Shot ☐ Yes ☐ No Date of last Tetanus______

Mobility: Independent Ambulation_____ Crutches_____ Braces____ Wheelchair_____ Walker_____

PRECAUTIONS or CONTRAINDICATIONS

Please note that the following conditions, if present, may represent precautions or contraindications to equine-assisted services. When completing this form, please mark any conditions that are present, and explain to what degree.

PSYCHOLOGICAL

x	Area of Concern	Description/Comments
	Animal Abuse	
	Dangerous to self/others (Self Injurious Behaviors)	
	Delusions/Hallucinations	
	Physical/Sexual/Emotional Abuse	
	Fire Settings	
	Alcohol/Substance Use	
	Suicidal Ideations	
	Homicidal Ideations	
	Significant Trauma History	

MEDICAL

x	Area of Concern	Description/Comments
	Allergies	
	Cardiac Condition	
	Blood Pressure Control	
	Exacerbations of medical conditions (RA, MS)	
	Hemophilia	
	Medical Instability	
	Migraines	
	PVD	
	Respiratory Compromise	
	Recent Surgeries	
	Weight Control Disorders	

NEUROLOGIC

x	Area of Concern	Description/Comments
	Hydrocephalus/shunt	
	Spina Bifida	
	Chiari II Malformation	
	Hydromyelia	
	Seizure Disorders	
	Tethered Cord	

ORTHOPEDIC

x	Area of Concern	Description/Comments
	Spinal Joint Fusion/Fixation	
	Spinal Joint Instabilities/Abnormalities	
	Atlantoaxial Instabilities (including neurological symptoms)	
	Heterotopic Ossification/Myositis Ossificans	
	Joint Subluxation and Dislocation	
	Osteoporosis – T-Score: _________ Date of exam: __________	
	Pathologic Fractures	
	Coxa Arthrosis	
	Cranial Deficits	
	History of Joint Replacement	
	Scoliosis/Kyphosis/Lordosis	
	Herniated/Slipped Disc	

OTHER

x	Area of Concern	Description/Comments
	Indwelling Catheter/Medical Equipment	
	Age under 4 years	
	Medications – ie photosensitivity	
	Poor Endurance	
	Skin Breakdown	
	Poor Head & Neck Control	
	Fatigue/Poor Endurance	

Please indicate any precautions/additional information not noted above :____

____

Initial here if none of the above listed precautions/contraindications are present:_______________

In my opinion, this individual can participate in supervised equine-assisted services. However, I understand that the HETRA will weigh the medical information above against the existing precautions and contraindications. I concur with a review/screening of the person's abilities/limitations by a licensed/credentialed health professional (PT, OT, Speech or Mental Health practitioner) in the implementing of an effective services.

Treating Physician Name (please print)____ Phone________________________

Treating Physician Signature____Date____________________________

Address_______________________________________City_________________________State____________Zip _____________

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact us at 402-359-8830.