Colorado Therapeutic Riding Center, Inc.
11968 Mineral Road, Longmont, CO 80504
PHONE: (303)652-9131 FAX: (303)532-0164 www.ctrcinc.org

Dear Health Care Provider:

Your patient is interested in participating in supervised equine activities. In order to safely provide this service, we request that you complete (or update) the attached Participant Medical History one-sided form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note 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 Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromyelia

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Setting
Heart Condition
Hemophilia
Medical Instability
Medications – e.g. photosensitivity
Migranes
PVD
Poor Endurance
Respiratory Compromise
Recent Surgeries
Skin Breakdown
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine activities, please contact me at (303) 652-9131 or headinstructor@ctrcinc.org.

Sincerely,
Michele Bruhn
Michele Bruhn
Head Instructor

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PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN STATEMENT *(Physician Completes)*

Participant's Name _____ Date of Birth _____

Address _____ Best Phone # _____

Name of Parent(s)/Guardian(s) _____

Height _____ **Weight** _____ Relevant Medications _____

Mobility: Independent Ambulation ☐ ***OR*** Assisted Ambulation: Braces ☐ Crutches ☐ Walker ☐ Wheelchair ☐

Special Precautions:
For Down Syndrome, this box must be checked: ☐ As the physician, I have conducted a medical examination including a complete neurologic exam within the past year that shows no evidence of Atlanto Axial Instability or Focal Neurologic Disorder (Comments:_____)

Seizures: Yes ☐ No ☐ Seizure Type _____ Date of Last Seizure _____
Changes to Seizure Activity in the past year? Yes ☐ No ☐ Now Controlled? Yes ☐ No ☐

Scoliosis: Yes ☐ No ☐ Degree of Scoliosis: _____

Shunt: Yes ☐ No ☐ Date of Last Revision _____

Primary Diagnosis/Presenting Concern _____ Date of Onset _____

Secondary Diagnosis/Presenting Concern _____

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

AREAS	YES	NO	COMMENTS
Visual			
Auditory			
Tactile Sensation			
Speech & Language			
Cognitive/Processing			
Learning & Development			
Psychological/Emotional/ Behavioral			
Muscular			
Balance			
Orthopedic – Note Scoliosis or Hip Subluxation/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. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional, as necessary, in the implementation of an effective equine activity program.

Date_____ *Name & Title (print)*_____ *MD DO NP PA*

Signature _____ *Phone* _____

Address _____ *City* _____ *State* _____ *Zip* _____