

Client's Name _____

Date _____

PHYSICIAN'S PRESCRIPTION

(Please complete both sides.)

Client's Name: _____

Prescription for Therapeutic Horseback Riding, where appropriate, for evaluation and treatment by a Physical, Occupational, and/or Speech Therapist in conjunction with **Greystone Manor Therapeutic Riding Center**.

Recommended Frequency: _____

Physician's Signature: _____ Date: _____

Please Print, Type, or Stamp:

Physician's Name: _____

Address: _____

Phone: _____

MEDICAL HISTORY

Date: _____

Client's Name: _____ DOB (MM/DD/YY): _____ Age: _____

Sex: M F Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Diagnosis: _____

Allergies: _____

Medications (Type, Purpose, Dose): _____

Tetanus Shot: (*Circle one*) Yes (Date ___/___/___) No

If Downs Syndrome, please indicate results of Cervical X-ray regarding Atlanto-Axial Subluxation:

(*Circle one*) Positive Negative X-ray (Date ___/___/___)

Please indicate if the client has a history of the following secondary problems by checking YES or NO.

If YES, please include COMPLETE pertinent information.

<u>Problem</u>	<u>Yes</u>	<u>No</u>	<u>If Yes, or History of, Describe</u>
Learning Disability	_____	_____	_____
Cognitive Impairment	_____	_____	_____
Psychological Impairment	_____	_____	_____
Speech Impairment	_____	_____	_____
Visual Impairment	_____	_____	Glasses? _____
Auditory Impairment	_____	_____	_____
Cardiac Problem	_____	_____	_____
CIRCULATORY	_____	_____	_____
PVD	_____	_____	_____
Postural Hypotension	_____	_____	_____
Hemophilia	_____	_____	_____
PULMONARY	_____	_____	_____
Asthma	_____	_____	_____
COPD	_____	_____	_____
NEUROLOGICAL	_____	_____	_____

Problem	Yes	No	If Yes, or History of, Describe
Seizures	_____	_____	Last Seizure Date ____/____/____.
Controlled?	_____	_____	Type? _____
Hydrocephalus	_____	_____	_____
Shunt	_____	_____	# Revisions: _____
Sensory Loss	_____	_____	_____
Pain	_____	_____	_____
MUSCULAR	_____	_____	_____
Contractures	_____	_____	_____
SKELETAL	_____	_____	_____
Spinal Column Injury	_____	_____	_____
Subluxing Joints	_____	_____	_____
Dislocating Joints	_____	_____	_____
Laminectomy/Fusion	_____	_____	_____
Scoliosis – Degree/Type/Brace/Last X-ray?	_____	_____	_____
Kyphosis/Lordosis – Degree/Type?	_____	_____	_____
Osteoporosis	_____	_____	_____
Joint Disease	_____	_____	_____
Fractures	_____	_____	_____
Location?	_____	_____	_____
Healed?	_____	_____	_____
Other	_____	_____	_____

Please indicate any medical problems not indicated above: _____

Please indicate special precautions or restrictions: _____

MOBILITY STATUS

	<u>Yes</u>	<u>No</u>
Is the client ambulatory?	_____	_____
Can the client ambulate independently?	_____	_____
If No, please describe:	_____	

PROSTHETICS/ORTHOTICS

Type: _____ Purpose: _____

Type: _____ Purpose: _____

Describe in the space below any additional information that might help us to work with this client.
Thank you for your time!