New Life Equine Therapy Facility

WHERE HEALING BEGINS

PARTICIPANT'S MEDICAL HISTORY & PHYSICIAN'S STATEMENT

Participant: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset _____

Past/ Prospective Surgeries: _____

Medications: _____

Seizure Type: _____

Shunt Present: Y ◯ N ◯ Date of last revision: _____

Special Precautions/ Needs: _____

Mobility: Independent Ambulation Y ◯ N ◯ Assisted Ambulation Y ◯ N ◯ Wheelchair Y ◯ N ◯

Braces/ Assistive Devices: _____

For those with Down Syndrome: AtlantoDens Interval X-rays, Dates: _____

Results : + ◯ - ◯

Neurologic Symptoms of AtlantoAxial Instability:

Please indicate current or past difficulties in the following systems/areas, including surgeries:

		Comments
Auditory	Y ◯ N ◯	
Visual	Y ◯ N ◯	
Tactile Sensation	Y ◯ N ◯	
Speech	Y ◯ N ◯	
Cardiac	Y ◯ N ◯	
Circulatory	Y ◯ N ◯	
Integumentary/Skin	Y ◯ N ◯	
Immunity	Y ◯ N ◯	
Pulmonary	Y ◯ N ◯	
Neurologic	Y ◯ N ◯	
Muscular	Y ◯ N ◯	
Balance	Y ◯ N ◯	
Orthopedic	Y ◯ N ◯	
Allergies	Y ◯ N ◯	
Learning Disability	Y ◯ N ◯	
Cognitive	Y ◯ N ◯	
Emotional/Psychological	Y ◯ N ◯	
Pain	Y ◯ N ◯	
Other	Y ◯ N ◯	

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding facility will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg PT,OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title:

License/UPIN Number:

Signature: Date:

New Life Equine Therapy Facility

WHERE HEALING BEGINS

REV 04/20/2023

SPEECH THERAPY QUESTIONNAIRE

Client Name: _____ DOB: _____ Age: _____

Diagnosis: _____ Date of Request: _____

The above named client has applied for Therapeutic Horseback Riding Sessions at New Life Equine Therapy Facility. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Speech Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Oral Motor Activities:

Any Helpful Hints for Working with This Person:

Speech Therapist: (Please Sign) _____ Date: _____

Return To: New Life Equine Therapy Facility, 14021 Susie Lane #B, Alvin, Tx 77511. Thank You for Your Participation.

New Life Equine Therapy Facility

PHYSICAL/OCCUPATIONAL THERAPY QUESTIONNAIRE

Client Name: _____ DOB: _____ Age: _____

Diagnosis: _____ Date of Request: _____

The above named client has applied for Therapeutic Horseback Riding Sessions at New Life Equine Therapy Facility. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

Physical Therapist: (Please Sign) _____ Date: _____

Additional Notes:

Return To: New Life Equine Therapy Facility, 14021 Susie Lane #B, Alvin, Tx 77511. Thank You for Your Participation.