



Triple H Equitherapy

NARHA Certified Therapeutic Horseback Riding Facility
791 Backhaus Rd, Pipe Creek TX 78063
 (830) 510-9515 Fax (830) 535-4208

Annual review date and initials

Date	Initials

Participant's Medical History & Physician's Statement

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

Address: _____ City _____ ST _____ ZIP _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

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

Describe any braces or assistive devices _____

For those with Down Syndrome: AtlantoDens Interval X-rays, date: _____ Result: + or —

Neurologic Symptoms of AtlantoAxial Instability: _____

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

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

Given the above diagnosis and medical information, this person is not precluded from participation in equine-assisted activities. I understand that the NARHA center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the NARHA center for ongoing evaluation to determine eligibility for participation.

Name/Title: _____ MD DO NP PA Other _____

Address: _____ City _____ ST _____ ZIP _____

Phone: () _____ License/UPIN Number: _____

Doctor's Signature: _____ Date: _____

Parent/guardian/caregiver Signature: _____ Date: _____