



Heaven's Gait Ranch, Inc.

Dear Health Care Provider:

Your patient _____
 (Participant's Name)

is interested in participating in programs and/or services at Heaven's Gait Ranch, Inc. In order to safely provide our services under the Professional Association of Therapeutic Horsemanship (PATH Intl.), our center requests that you complete the attached Medical History and Physician's Statement Forms. Please note that the following conditions may suggest precautions and contraindications to mounted activities and/or therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic	Medical/Psychological
Atlantoaxial Instability (include neurologic symptoms)	Allergies
Coxarthrosis	Animal Abuse
Cranial Defects	Cardiac Condition
Heterotopic Ossification/Myositis Ossificans	Physical/Sexual/Emotional Abuse
Joint subluxation/dislocation	Blood Pressure Control
Osteoporosis	Dangerous to Self or Others
Pathologic Fractures	Exacerbations of Medical Conditions (e.g., RA, MS)
Spinal Joint Fusion/Fixation	Fire Setting
Spinal Joint Instability/Abnormalities	Hemophilia
Neurologic:	Medical Instability
Hydrocephalus/Shunt	Migraines
Seizure	PVD
Sensory Deficit	Respiratory Compromise
Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia	Recent Surgeries
Other:	Substance Abuse
Age (under 4 years)	Thought Control Disorders
Indwelling Catheters/Medical Equipment	Weight Control Disorder
Medications (e.g., photosensitivity)	
Poor Endurance	
Skin Breakdown	

Participant's Medical History



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***Note: The participant's physician must complete this form. Parent/Guardian signature is also required.**

Participant's Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____

Primary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Secondary Diagnosis: _____ Date of Onset: _____

Current Status: _____

Past Surgeries: _____ Date: _____

Prospective Surgeries: _____ Date: _____

Medications (include prescription and over-the-counter, name, dose, and frequency):

Side Effects: _____

Does this participant have a history of seizures? Yes: _____ No: _____

If yes, please provide the following information.

Triggers: _____ Type of Seizure: _____

Controlled: Yes: _____ No: _____ Date of Last Seizure: _____

Shunt Present: Yes: _____ No: _____ Date of last revision: _____

Special Precautions/Needs: _____

Mobility Assessment:

Independent Ambulation: Yes: _____ No: _____

Assisted Ambulation: Yes: _____ No: _____

Wheelchair: Yes: _____ No: _____

Braces/Assistive Devices: _____

Date of last Atlantoaxial Instability neurologic exam: _____
(if participant has Down Syndrome)

Physician Signature _____ **Date:** _____

_____ **Date:** _____

Signature of Participant / Parent or Guardian (if participant is under 18 years old)



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Participant's Physician's Statement

***Note: The participant's physician must complete this form.**

Please complete the following chart based on your knowledge of this participant.

Does the participant have a history of concerns in the following areas? Indicate yes or no. Add comments to explain.

Category	Yes	No	Comments	Category	Yes	No	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary/Skin				Emotional			
Immunity				Psychological			
Pulmonary				Pain			
Neurologic				Other			

Additional Comments:

Physician's Statement

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

Name/Title: _____ MD DO NP PA Other: _____

Signature: _____ Date: _____

Address: _____

Phone: (____) _____ EXT _____ License/UPIN Number: _____