Triple H Equitherapy Center

Horses Helping the Handicapped, Inc.
PATH, Int'l Certified Therapeutic Horsemanship Facility
791 Backhaus Road; Pipe Creek, Texas 78063
(830) 510-9515 Office (830) 535-4208 Fax

Participant's Health History

Participant Name: ____________________________Gender: ___ DOB: __________ Height: ________ Weight: _____
Address: _______________________________________ City: ____________________ State: _______ Zip: ________
Diagnosis *(mandatory)*: ____ 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: ____
____

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			
Other			

Parent/Guardian/Caregiver Signature: ______________________________ Date: ______________

Medical Professional's Statement

For those with Down Syndrome: AtlantoDens Interval X-Rays Date: _________ Result: + or —
Neurologic Symptoms of AtlantoAxial Instability: ____

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

Name: ____ MD DO PA NP Other___
Address: ___________________________________ City ________________ State: ____ Zip: _____________
Phone: _____________________________ Email: ____
License/UPIN Number: ________________ Signature: ________________________________ Date: _________

Reviewed By: Instructor: ______________ Signature: ______________ Date: ______
Head Instructor: ______________ Signature: ______________ Date: ______