



P.O. Box 1102
 MINNETONKA, MN 55345
 (952) 934-0057
 WWW.WECANRIDE.ORG

CLIENT MEDICAL HISTORY
 TO BE FILLED IN BY PHYSICIAN
 (PAGE 1 OF 2)

NAME: _____ M F DATE OF BIRTH: _____
 ADDRESS (w/ CITY & ZIP): _____
 PARENT/GUARDIAN: _____
 DIAGNOSIS: _____
 HEIGHT: _____ WEIGHT: _____ DATE OF ONSET: _____
 DATE OF LAST TETANUS SHOT: _____
 SEIZURE TYPE: _____ CONTROLLED: _____
 DATE OF LAST SEIZURE: _____

Please indicate if the client has a problem and/or surgeries in any of the following areas by checking Yes or No.
 If yes, please comment.

AREAS	YES	NO	COMMENTS
Auditory			
Visual			
Speech			
Cardiac			
Circulatory			
Pulmonary			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment			
Medications			
Other			

MOBILITY (PLEASE CIRCLE): INDEPENDENT CANE CRUTCHES BRACES WALKER WHEELCHAIR

PLEASE INDICATE ANY SPECIAL PRECAUTIONS: _____

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities as described on the enclosed sheet. However, I understand that *We Can Ride, Inc.* will determine whether they can provide services safely.

PHYSICIAN NAME (PLEASE PRINT): _____ **DATE** _____
PHYSICIAN SIGNATURE: _____ **OR STAMP ADDRESS HERE:** _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE: _____



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INFORMATION FOR PHYSICIANS

The following conditions may impact therapeutic horseback riding.
Please circle conditions involved and indicate severity.

ORTHOPEDIC

Spinal fusion
Spinal instability/abnormality
Atlantoaxial instability
Scoliosis
Kyphosis
Lordosis
Hip subluxation/dislocation
Osteoporosis
Pathologic fractures
Arthritis
Heterotopic ossification
Osteogenesis imperfecta
Cranial defects
Spinal orthoses
Internal spinal stabilization devices

MEDICAL/SURGICAL

Allergies
Cancer
Poor endurance
Recent surgery
Diabetes
Peripheral vascular disease
Varicose veins
Hemophilia
Hypertension
Serious heart condition
Stroke
Muscular dystrophy
Asthma

NEUROLOGICAL

Hydrocephalus/shunt
Spina bifida
Tethered cord
Chiari II malformation
Hydromyelia
Paralysis due to spinal cord injury
Seizure disorder
Cerebral palsy

OTHER CONCERNS

Behavior problems
Learning problems
Mental retardation
In-dwelling catheter, urinary or vascular
Pacemaker
Glasses, contacts, hearing aid
Tracheotomy, feeding tube

When completed by the physician, please return this form to:

We Can Ride
address above.

DATE COMPLETED: _____