Three Gaits, Inc.

Therapeutic Horsemanship Center

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Client Medical History & Physician's Statement

*REQUIRED

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

Address:_____ City:_____ State:_____ Zip:_____

*Phone:_____ Email:_____

Diagnosis:_____ Date of Onset:_____

Past/Prospective Surgeries:_____

Medications:_____ For:_____

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

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

Braces/Assistive Devices:_____ Shunt Present: Y N Date of Last Revision:_____

For those with Down syndrome: Neurologic Symptoms of Atlantoaxial Instability: ☐Present ☐Absent

Please indicate current or past special needs in the following systems/areas, including surgeries. These conditions may suggest precautions and contraindications to equine activities.

- Auditory no yes _____
- Visual no yes _____
- Tactile Sensation no yes _____
- Speech no yes _____
- Cardiac no yes _____
- Circulatory no yes _____
- Integumentary/Skin no yes _____
- Immunity no yes _____
- Pulmonary no yes _____
- Neurologic no yes _____
- Muscular no yes _____
- Balance no yes _____
- Orthopedic no yes _____
- Allergies no yes _____
- Learning Disability no yes _____
- Cognitive no yes _____
- Emotional/Psychological no yes _____
- Pain no yes _____

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

Name/Title:_____ MD DO NP PA Other_____

Address:_____ City:_____ State:_____ Zip:_____

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

Signature:_____ *Date:_____