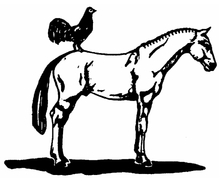

THORNCROFT EQUESTRIAN CENTER –
190 LINE ROAD, MALVERN, PA 19355
Phone: 610-644-1963/Fax: 610-644-9342

MEDICAL HISTORY

TO BE COMPLETED BY PHYSICIAN *PLEASE WRITE LEGIBLY*

NAME: ________________________________ DATE: ______________________ PHONE: ____________________

E-MAIL ADDRESS:____

ADDRESS: ____

DATE OF BIRTH: ____________________ AGE: _________ SEX: ________ HEIGHT: ________ WEIGHT: ________

PARENT/GUARDIAN NAME: ____

HEALTH INSURANCE COMPANY: ___________________________________ POLICY NUMBER: _________________

Physically Handicapped: Yes _____ No _____ Mentally Retarded: Yes _____ No _____

Emotionally Disturbed: Yes _____ No _____ Learning Disabled: Yes _____ No _____

DIAGNOSIS: ____

Cause: ____ Onset: _____________________________________

Limbs Affected: ____

If Spinal Cord Injury, what vertebral level? ____

If Down Syndrome, is Atlantoaxial Instability present (AAI): ____

If Down Syndrome Date of Cervical Spine X-ray: ________________ Age at the time of x-ray: _________________

Estimate of mental ability: ____

MOBILITY STATUS:
Can the student ambulate? Yes _____ No ______

Assistance: Independent _________Minimal _________ Moderate _________ Maximal __________

Physical Aids: Canes _______ Crutches _______ Walker _______ Wheelchair ______ Braces ______

Please describe any other additional information that might help us to work with this student. (Medications, fears/concerns, support system, and other interests, etc.) ____

____

____

____

Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

Problem	Yes	No	Description (*PLEASE PRINT*)
ALLERGIES			
VISION			
HEARING			
COMMUNICATION/SPEECH			
CARDIAC Pulse: Blood Pressure:			
CIRCULARTORY Hemophilia			
PULMONARY			
METABOLIC/G.I.G.U. Diabetes, Bladder/Bowel			
SKIN & SOFT TISSUE Pressure sores			
PAST/RECENT SURGERY/SURGERIES			Date(s)
CHRONIC PAIN			
MEDICATION			
NEUROLOGICAL			
SEIZURE			Controlled: Yes/No Type: Date of Last: If No, How Often: Indications of Seizures:
BEHAVIORAL			
MUSCULAR/Contractures			
SKELETAL (A) - Subluxing Hips, Fractures			
SKELETAL (B) - Scoliosis, Kyphosis, Lordosis,			Degrees:
CONTAGIOUS CONDITION			Hepatitis _____ AIDS ____ Other:

Physician's Signature: ____ **Date**: ____________________

Physician's Name (Please Print): ____ **Phone**: __________________

Office Name: ________________________________**Address**____

THERAPEUTIC HORSEBACK RIDING REFERRAL

PLEASE WRITE LEGIBLY AND IN DETAIL

STUDENT'S NAME: ______________________________________ **PHONE**: ______________

DIAGNOSIS: **ONSET:**

____ _______________
____ _______________
____ _______________
____ _______________
____ _______________
____ _______________
____ _______________
____ _______________
____ _______________

PRECAUTIONS:

____
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____
____

ADDITIONAL COMMENTS:

____
____
____
____
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____
____

REFERRING PHYSICIAN: ___________________________________ **DATE:** ____________

Please Print 11/07