



P.O. Box 2282  
Morristown, TN 37816  
423-585-0331

Date \_\_\_\_\_

Dear Physician:

Your patient, \_\_\_\_\_, is interested in participating in supervised equestrian activities. In order to safely provide this service, our center requests that you complete/update the following attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding; therefore, when completing this form, please note whether these conditions are present and to what degree.

**Orthopedic**

Atlantoaxial Instability- include neurological symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossifications/ Myositis Ossificans  
Joint Subluxation/ Dislocation  
Osteoporsis  
Pathological Fractures  
Spinal Fusion/ Fixation  
Spinal Instability/ Abnormalities

**Neurologic**

Hydrocephalus/ Shunt  
Seizure  
Spina Bifida/ Chiari II Malformation/ Tethered Cord  
Hydromyelia

**Other**

Indwelling Catheters  
Medications, i.e. photosensitivity  
Poor Endurance  
Skin Breakdown

**Medical/ Psychological**

Allergies  
Animal Abuse  
Physical/ Sexual/Emotional Abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical conditions  
Fire Settings  
Heart Conditions  
Medical Instability  
Migraines  
PVD  
Respiratory Compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorders

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equestrian activities, please feel free to contact the center.