46 Reynolds Rd
Fort Edward, NY 12828
Phone: (518) 573-0239
Fax: (518) 747-2194

Date: _____

Dear Provider:

(Client's name)_____ is

____ Interested in participating in equine assisted psychotherapy

____ Interested in continuing to participate in equine assisted psychotherapy

In order to safely provide this service, our program requests that you complete/update the attached Medical History and Physician's Statement form. Please note that the following conditions may suggest precautions or contraindications to equine assisted psychotherapy. Therefore, when completing this form, please note whether these conditions are present, and to what degree:

ORTHOPEDIC MEDICAL/PSYCHOLOGICAL

Atlantoaxial Instability - include neurologic symptoms
Allergies
Coxa Arthrosis
Animal Abuse
Cranial Deficits
Physical/Sexual/Emotional Abuse
Heterotopic Ossification/Myositis Ossificans
Blood Pressure Control
Joint subluxation/dislocation
Dangerous to self or others
Osteoporosis
Exacerbations of medical conditions
Pathologic Fractures
Fire Setting
Spinal Fusion/Fixation
Heart conditions
Spinal Instability/Abnormalities
Hemophilia
Medical Instability

NEUROLOGIC

Migraines
Hydrocephalus/Shunt
Peripheral Vascular Disease
Seizure
Respiratory Compromise
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia
Recent Surgeries
Substance Abuse

OTHER

Thought control disorders
Obesity
Age - under 4 year
Weight control disorder
Indwelling Catheters
Medications - i.e. photosensitivity
Poor Endurance
Skin Breakdown

Thank you very much for your assistance. If you have any questions or concerns regarding this person's participation in equine assisted psychotherapy, please contact me at (518)573-0239.

Sincerely,

Shannon Myles, LCSWR

CLIENT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____
Height: _____ Weight: _____
Address:
_____
Previous Mental Health Diagnoses:
_____
Past Psychological/Mental Health Testing:
_____
Past/Prospective Surgeries:
_____
Medications:
_____
_____
Seizures? Type?: _____Controlled?: Yes No Date of last seizure:_____
Date of last Tetanus Shot: _____
Special Precautions/Needs:
_____
_____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Yes	No	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/psychological			
Pain			
Other			

To my knowledge there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that Adirondack Equine Assisted Psychotherapy will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by Shannon Myles, LCSWR.

Name/Title: _____
Signature: _____ Date: _____
Address: _____ City _____
State _____ Zip _____
Phone: (____) _____License/UPIN Number: _____