Horse Power Healing Center, Inc.
S.101 W.34628 Hwy LO
Eagle, WI 53119
Phone: 262-751-6525 or 262-594-3667
Fax: 262-594-5136
Email:horsepowerhealingcenter@yahoo.com
www.horsepowerhealingcenter.com

Date: _____

Dear Healthcare Provider:

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

Orthopedic
Atlantoaxial Instability-include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/Dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instabilities/ Abnormalities

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/HydroMyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of Medical Conditions (ie. M.S., RA)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you so much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact our center.

Sincerely,

Horse Power Healing Center, Inc.

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Medical History & Physician's Statement

(to be completed by physician)

Participant: _____DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

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

Special Precautions/Needs: _____

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

Braces/Assistive Devices: _____

For those with Downs Syndrome: AtlantoDens Interval X-rays, date: _____ Result + --

Neurological Symptoms of AtlantoAxial Instability: _____

***Please indicate past or present special needs in the following systems/areas, including surgeries**:*

	Y	**N**	**Comments**
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

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

Name/Title: _____ MD DO

Signature: _____ Date: _____

Address: _____

Phone: _____ License/UPIN Number: _____