STEP UP at New Forest Equestrian Center
P.O. Box 2918
Glenville, NY 12325-0918
Phone (barn): (518) 374-5116

Medical History

Date: _____

Clients' Name _____ DOB: _____ Age: _____

Sex: _____ Height: _____ Weight _____ Pulse:_____ B.P.: _____

Diagnosis: _____

Cause: _____

Medications (type, purpose, dose): _____

_____

If Downs Syndrome, Atlanto-Axial Subluxation? Yes _____ No _____

Cervical X-ray for Atlanto-Axial Subluxation: Pos __ Neg __ X-ray Date ___/___/___

Tetanus Shot Yes _____ No _____ Date ___/___/___

_____

Please indicate if the client has or had a history of, the following secondary problems by checking YES or NO. If YES, please include complete information pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
AUDITORY IMPAIRMENT	___	___	_____
LEARNING DISABILITY	___	___	_____
MENTAL IMPAIRMENT	___	___	_____
PSYCHOLOGICAL IMPAIRMENT	___	___	_____
SPEECH IMPAIRMENT	___	___	_____
VISUAL IMPAIRMENT	___	___	Glasses_____
ALLERGIES	___	___	_____
CARDIAC	___	___	_____
CIRCULATORY	___	___	_____
PVD	___	___	_____

Postural Hypotension	___	___	_____
Hemophilia	___	___	_____
PULMONARY	___	___	_____
Asthma/COPD	___	___	_____
NEUROLOGICAL	___	___	_____
Seizures	___	___	_____
Controlled	___	___	_____
Last Seizure	___/___/___		

PROBLEM	YES	NO	IF YES, OR HISTORY OF, DESCRIBE
Hydrocephalus	___	___	_____
Shunt	___	___	# Revisions: _____
Sensory Loss	___	___	_____
Pain	___	___	_____
SKELETAL	___	___	_____
Spinal Column Injury	___	___	_____
Subluxing Joints	___	___	_____
Dislocating Joints	___	___	_____
Laminectomy/Fusion	___	___	_____
Scoliosis	___	___	Degree/Type/Brace/Last X- ray:_____ _____
Kyphosis/Lordosis	___	___	Degree/Type:_____
Spondylolisthesis	___	___	_____
Spinal Abnormality	___	___	_____
Osteoporosis	___	___	_____
Heterotrophis Ossification	___	___	_____
Joint Disease	___	___	_____
Cranial Defects	___	___	_____
Fractures	___	___	Location _____ Healed _____
Other	___	___	_____

_____

_____

MEDICAL HISTORY

Please indicate any medical/psychological problems not indicated above (i.e. violent outbursts, biting, hitting, screaming, scratching, animal abuse, etc.)_____

_____

_____

Please indicate special precautions_____

_____

_____

MOBILITY STATUS

Ambulatory? Yes ___ No ___

Can the patient ambulate independently? Yes ___ No ___

PROSTHETICS/ORTHOTICS

Type: _____ Purpose: _____

Type: _____ Purpose: _____

Please describe any other additional information that might help us work with this student.

Thank you for your time.
Karen Stanley-White PT MSCS

Physician's Signature: _____
(please print, type or stamp)

Date ___/___/_____

Physician's Name: _____

Address: _____

Phone: _____