



True Friends
 10509 108th Street NW
 Annandale, MN 55302
 registration@truefriends.org
 952.852.0101

**To be completed by a
 physician/health care professional.**

Contraindications to Hippotherapy

Dear Health Care Provider,
 Your patient is interested in participating in supervised equine activities. In order to safely provide this service, our center requests that you complete/update the attached Medical History and 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. If you have any questions or concerns regarding this patient's participation in equine assisted activities, please feel free to contact the center at the address/email indicated above.

Sincerely,

Director of Therapy and Adaptive Riding

Patient Information

Name: _____
First
Middle
Last

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Primary Diagnosis:

| Orthopedic | NO | YES | COMMENTS |
|--|--------------------------|--------------------------|----------|
| Atlantoaxial Instability - include neurologic symptoms | <input type="checkbox"/> | <input type="checkbox"/> | |
| Coxa Arthrosis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cranial Deficits | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heterotopic Ossification/Myositis Ossificans | <input type="checkbox"/> | <input type="checkbox"/> | |
| Joint subluxation/dislocation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pathologic Fractures | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spinal Joint Fusion/Fixation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spinal Joint Instability/Abnormalities | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neurologic | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hydrocephalus/Shunt | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seizure | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spina Bifida/Chiari II malformation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tethered Cord/Hydromyelia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Medical/Psychological | <input type="checkbox"/> | <input type="checkbox"/> | |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | |
| Animal Abuse | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cardiac Condition | <input type="checkbox"/> | <input type="checkbox"/> | |

| | | | |
|--|--------------------------|--------------------------|--|
| Physical/Sexual/Emotional Abuse | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blood Pressure Control | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dangerous to self or others | <input type="checkbox"/> | <input type="checkbox"/> | |
| Exacerbations of medical conditions (i.e. RA, MS) | <input type="checkbox"/> | <input type="checkbox"/> | |

| | | | |
|---|--------------------------|--------------------------|--|
| Fire Settings | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Medical Instability | <input type="checkbox"/> | <input type="checkbox"/> | |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | |
| PVD | <input type="checkbox"/> | <input type="checkbox"/> | |
| Respiratory Compromise | <input type="checkbox"/> | <input type="checkbox"/> | |
| Recent Surgeries | <input type="checkbox"/> | <input type="checkbox"/> | |
| Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> | |
| Thought Control Disorders | <input type="checkbox"/> | <input type="checkbox"/> | |
| Weight Control Disorder | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | |
| Age - under 4 years | <input type="checkbox"/> | <input type="checkbox"/> | |
| Indwelling Catheters/Medical Equipment | <input type="checkbox"/> | <input type="checkbox"/> | |
| Medications - i.e. photosensitivity | <input type="checkbox"/> | <input type="checkbox"/> | |
| Poor Endurance | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Breakdown | <input type="checkbox"/> | <input type="checkbox"/> | |

Please provide your professional opinion as to whether or not your patient is a suitable candidate for mounted horseback riding activities:

Physician's Signature **Date**

Physician's Printed Name

Please send materials to:
True Friends
Attn: Registration
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Questions? Please call Customer Relations at 952.852.0101 or email registration@truefriends.org