Seaton Hackney STABLES

440 South Street, Morristown NJ 07960 - 973-644-3355 - seatonh@verizon.net

Application and Health History

Background Information

Today's Date: ____/____/___

Client's Name: _____DOB: _____/_____/_____ Gender: ___M____F

Age: ____years ____months Height: _____ Weight:_____ Hand Preference: ____L____R

Mother's Name: _____ Father's Name: _____

Address: _____

Phone Number: _____Fax Number: _____

Mother's Cell Phone:_____ Father's Cell Phone:_____

Email Address:_____

Mother's Occupation: _____Work No.: _____

Father's Occupation: _____Work No.: _____

Siblings:

_____ Age: _____

_____ Age: _____

_____ Age: _____

Referral Source: _____ Language Spoken: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnosis: _____

Precautions: _____

Insurance Information

Insurance Company: _____Patient ID #: _____

Phone #: _____ Address: _____

Current Skills

Please describe your child's…..

Eye contact

_____

Gestures

_____

Speech Sounds

_____

Words

_____

Sentences

_____

Behaviors

_____

Gross Motor Skills

_____

Fine Motor Skills

_____

Sensory Processing

_____

Hearing

_____

Vision

_____

Feeding Skills

_____

Respiration/Circulation

_____

Psycho/Social Function and Mental Health

_____

Allergies

_____

Primary Concerns and Goals

_____

_____

_____

_____

_____

_____

_____

Name of person completing this form: _____
Relationship: _____
Signature: _____
Date: _____/_____/_____

*** Please provide copies of recent IEP, evaluations and/or progress reports.*

PHOTO RELEASE

I ___DO/___DO NOT consent to and authorize the use and reproduction by Seaton Hackney Stables of any and all photographs and any other audio/visual materials taken of my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:_____Date:_____
Parent or Legal Guardian

PHYSICIAN'S STATEMENT

Dear Doctor,

Your patient, _____is interested in participating in equine assisted therapies and activities at Seaton Hackney Stables. To safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine assisted therapies and activities. Therefore, when completing this form, please note whether these conditions are present and to what degree

Absolute Contraindications for Adaptive Riding

- Acute mental health disorders that would be unsafe (e.g., fire-setting, suicidal, animal abuse, violent behavior)
- Acute herniated disc with or without nerve root compression
- Chiari II malformation with neurologic symptoms
- Atlantoaxial instability, a displacement of the C1 vertebra in relation to the C2 vertebra as seen on x-ray or computed tomography of significant amount (generally agreed to be greater than 4 mm for a child), with or without neurologic signs as assessed by a qualified physician; this condition is seen in diagnoses with ligamentous laxity such as Down Syndrome or juvenile rheumatoid arthritis.
- Coxa arthrosis, a degeneration of the hip joint; the femoral head is flattened and functions like a hinge joint versus a ball and socket joint. Sitting on a horse puts extreme stress on this joint.
- Seizures uncontrolled by medications
- Hemophilia with recent history of bleeding episodes Indwelling urethral catheters
- Medical conditions during acute exacerbations (e.g., rheumatoid arthritis, herniated nucleus pulposus, multiple sclerosis, diabetes)
- Open wounds over a weight-bearing surface Pathologic fractures without successful treatment of the underlying pathology (e.g., severe osteoporosis, osteogenesis imperfecta, bone tumor)
- Tethered cord with symptoms
- Unstable spine or joints including unstable internal Hardware

Precautions/Considerations for Patient Selection

- Age (minimum age is 5)
- Cognitive ability
- Sitting balance
- Poor head control/inability to wear a helmet
- Spasticity/Muscle stiffness/Joint stiffness
- Height and weight
-Mobility and alignment
- Limited mobility and/or malalignment
- Fear or anxiety
- Environmental considerations
-Cranial deficits
- Hetertropic ossification/myositis ossificans
- Osteoporosis
- Joint subluxation/dislocation
- Spinal fusion/fixation
-Spina bifida/Spinal instability/abnormalities
-Hydrocephalus/shunt
- Seizure disorder
- Medications
- Poor endurance
- Skin breakdown
- Allergies
- Blood pressure control
- Physical/sexual/emotional abuse
-Exacerbations of medical conditions
-Migraines
- Medical instability
- Thought control disorders
- Weight control disorders
- Respiratory compromise
- Heart conditions
- Recent surgeries
- Substance Abuse
- PVL

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted therapies and activities, please feel free to contact the center at the address or phone number indicated above.

Sincerely,
Seaton Hackney Stables

PHYSICIAN'S STATEMENT

Patient: _____DOB:_____Height:_____Weight:_____
Address: _____
Dianosis: _____Date of Onset:_____
Past/Prospective Surgeries:_____
Medications:_____
Seizure Type: _____Controlled: Y N Date of Last Seizure: _____
Shunt Present: Y N Date of Last Revision: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair Y N Down Syndrome: Y N AtlantoDens Interval X-Rays, date: _____ Result: + --
Neurologic symptoms of AtlantoAxial Instability: _____
Please indicate current past or special needs in the following systems/areas, including surgeries:
Auditory: _____
Visual: _____
Sensory Processing:_____
Speech: _____
Cardiac: _____
Circulatory: _____
Integumentary/Skin:_____
Immunity: _____
Pulmonary: _____
Neurologic: _____
Muscular: _____
Balance: _____
Orthopedic: _____
Allergies: _____
Learning Disability:_____
Cognition:_____
Emotional/Psychological: _____
Pain: _____
Other: _____

To my knowledge there is no medical reason why this patient cannot participate in equine assisted therapies and activities. However, I understand that Seaton Hackney Stables will weigh the medical information above against the existing precautions and contraindications..

Name/Title: _____MD DO NP PA Other: _____
Signature: _____
License/UPINNumber:_____
Address:_____Phone_____Date:_____

PLEASE STAMP WITH THE PRACTICE ID