**Sebastian Riding Associates, Inc.**
*Therapeutic & Educational Riding Programs for Children & Adults with Disabilities*
3589 B Water Street ♦ Collegeville, PA 19426 ♦610-489-3741 ♦ www.sebastianriding.org

# MEDICAL HISTORY

*To be Completed by Client's Physician*

Client's Name: ______________________________________________

Age:__________ Date of Birth:_________________ Height:________Weight:_______________

Physical Disability Yes ☐ No ☐ Intellectual Disability Yes ☐ No ☐

Learning Disability Yes ☐ No ☐ Emotional Disability Yes ☐ No ☐

Estimate of Mental Ability: ______________________________________

Diagnosis: ______________________________________________

Cause: ________________________________ Onset: ___________________________________

Limbs Affected: _________________________________________

If spinal cord involvement, what vertebrae level: ______________________________

If Downs Syndrome:

A. Lateral view roentgenograms of the upper cervical region in:

1. Full Flexion: positive ___________ negative ___________ Date: ______________
2. Extension: positive ___________ negative ___________ Date: ______________

B. Atlanto-axial instability or neurological disorder: Yes ☐ No ☐

List all current prescribed medications:

______________________________________________

______________________________________________

Please indicate if the client has any of the following secondary problems by checking yes or no. If yes, please provide detailed information.

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Visual | | | |
| Hearing | | | |

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Speech | | | |
| Cardiac | | | |

Blood Pressure: ________________________

Pulse: ________________________________

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Pulmonary | | | |
| Circulatory | | | |
| Peripheral Vascular Disorder | | | |
| Hemophilia | | | |
| Metabolic/GI-GU | | | |
| Diabetes | | | |
| Bladder/Bowel Control | | | |
| Skin and Soft Tissue | | | |
| Pressure Sore | | | |

Healed: Yes ☐ No ☐ Location: _______________________________

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Pain | | | |
| Surgery | | | |

Procedure: ________________________________ Date: ______________

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Neurological | | | |
| Sensory Loss | | | |
| Hydrocephalus | | | |
| Shunt | | | |
| Seizures | | | |
| Controlled | | | |

Last Seizure Date & Type: ____________________________________

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Musculature | | | |
| Contractures | | | |
| Skeletal | | | |
| Hip Subluxation | | | |
| Hip Dislocation | | | |
| Spinal Laminectomy | | | |
| Scoliosis | | | |

Degree:_______________ Location:_____________________ Last X-ray: _____________

| PROBLEM | NO | YES | If YES, please provide details. |
|---|---|---|---|
| Kyphosis, Lordosis | | | |

Degree:_______________ Type:________________________ Last X-ray: _____________

| | | | |
|---|---|---|---|
| Spondylosis | | | |
| Spondylosisthesis | | | |
| Osteoporosis | | | |
| Heterotrophic Ossification | | | |
| Arthrodesis | | | |
| Fractures | | | |

Healed: Yes ☐ No ☐ Location: ___________________________________

**Mobility Status**

Can the client ambulate? Yes ☐ No ☐

Assistance: Independent ☐ Minimal ☐ Moderate ☐ Maximal ☐

One person assist ☐ Two person assist ☐

Physical Aids: Canes ☐ Crutches ☐ Walker ☐ Rolling Walker ☐

Orthotics/Braces (type): _________________________________________________________

Does the client use a wheelchair? Yes ☐ No ☐ Type: ___________________________

Can the client propel the wheelchair? Yes ☐ No ☐

✓ Physician's Signature: __________________________________ Date:__________________________

Physician's Name: __________________________________________ Phone: ___________________

*(please print)*