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 ☐ Mental Retardation Yes ☐ No ☐

Learning Disability Yes ☐ No ☐ Emotional Disturbance 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			

PROBLEM	NO	YES	If YES, please provide details.
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)