WILLOW CREEK RANCH, INC.

PATH INTERNATIONAL

Participant Medical History
To Be Completed by Physician

Dear Healthcare Provider:

Your patient, ______________________________ DOB: ________________
(Participant's Name)
Diagnosis: ______________________________ Date of Onset: ________________
is interested in participating in supervised Equine Assisted Services: Therapy – Learning – Horsemanship at Willow Creek Ranch.

In order to safely provide services, our center requests that you complete the Participant Medical History form. ***Please indicate current or past conditions in the following systems/areas including surgeries. These conditions may suggest precautions and contraindications to equine assisted services.***

Orthopedic
- □ Atlantoaxial Instability: ________________
  - □ Present □ Absent
  - include Neurologic symptoms: ________________
- □ Coxarthrosis: ________________
- □ Cranial Deficits: ________________
- □ Heterotopic Ossification: ________________
- □ Myositis Ossificans: ________________
- □ Joint subluxation/dislocation: ________________
- □ Osteoporosis: ________________
- □ Pathologic Fractures: ________________
- □ Spinal Joint Fusion: ________________
- □ Spinal Joint Instability: ________________

Neurologic
- □ Hydrocephalus: ________________
- □ Shunt Present: □ Yes □ No
  - Date of Last Revision: ________________
  - Special Precautions/Needs: ________________
- □ Seizure Type: ________________
  - Controlled: □ Yes □ No
  - Date of Last Seizure: ________________
- □ Spina Bilfida: ________________

Other
- □ G-tube/J-tube: ________________
- □ Braces/Assistive Devices: ________________

Medical/Psychological
- □ Allergies: ________________
- □ Animal Abuse: ________________
- □ Blood Pressure Control: ________________
- □ Cardiac Condition: ________________
- □ Circulatory: ________________
- □ Dangerous to Self or Others: ________________
- □ Digestive: ________________
- □ Exacerbations of medical conditions (e.g. RA, MS): ________________
- □ Hemophilia: ________________
- □ Immunity: ________________
- □ Migraines: ________________
- □ Muscular: ________________
- □ PVD: ________________
- □ Physical/Sexual/Emotional Abuse: ________________
- □ Chronic Pain: ________________
- □ Respiratory Compromise: ________________
- □ Substance Abuse: ________________
- □ Weight Control Disorders: ________________

Mobility: Independent Ambulation: □ Yes □ No Assisted Ambulation: □ Yes □ No Wheelchair: □ Yes □ No

Past Surgeries/Hospitalizations: ______________________________

____

Thank you very much for your assistance, please sign and date the attached page. If you have any questions or concerns regarding this patient's participation in Equine Assisted Services: Therapy – Learning – Horsemanship, please feel free to contact me directly by phone at 414-791-2509.

Sincerely,

Jennifer Pape, Executive Director

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Return Participant Medical History form, or scan forms to wcrvolunteercoordinator@mail.com, subject: Participant MD form

Willow Creek Ranch
7404 Northwest Hwy 83
Mukwonago, WI 53149

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equine assisted services. I understand that the PATH Intl. center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH Intl. center for ongoing evaluation to determine eligibility for participation.

Print Name/Title: ____ MD DO NP PA Other:_________

Signature: ____ Date: _______________________________________

Address: ____

Phone: ____

License/UPIN Number:____License Expiration: ____________________