6919 Keystone Road
Richmond IL 60071
815-653-9374 Fax 815-728-1224
info@mainstayfarm.org www.mainstayfarm.org

2023 Client's Medical History & Physician's Statement

Dear Physician:

Your patient, ______________________ would like to participate in equestrian activities at Main Stay Therapeutic Farm, Inc. and is due for an updated medical status. Please review his/her current medical status and complete the following information. Main Stay Therapeutic Farm does not require an office visit for this update. Please address occurrences over the past year including surgeries, illnesses, hospitalization, changes in medications, treatment, weight or behavior. **Please indicate current height and weight.**

Date:___________________________

Name: Date of Birth: Age

Height:________**Weight**:_________ **M** **F** **Other(please specify)**______________

Diagnosis: ___________________________________
Date of Onset:_________________________________
Cause: ____

Medications:(Type, Purpose, Dosage)

____

Seizures? Y N 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

Braces/Assistive Devices: ____

Tetanus Shot: Yes ________No _______ Date: ________________

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Please indicate current or past special needs in the following systems/areas, including surgeries: (These conditions may suggest precautions and contraindications to equine activities)

	Yes	No
Allergies		
Auditory		
Balance		
Cardiac		
Circulatory		
Cognitive		
Cranial Defects		
Emotional/Psychological		
Fractures-Location/Healed		
Heterotopic Ossification		
Immunity		
Integumentary/Skin		
Learning Disabilities		

	Yes	No
Muscular		
Neurological		
Orthopedic		
Osteoporosis		
Pain		
Pulmonary		
Scoliosis – Degree/Type		
Skeletal		
Speech		
Spinal Column Abnormalities		
Spinal Column Injury		
Tactile Sensation/Sensory		
Visual		

Comments:

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MEDICAL HISTORY

Past/Prospective surgeries:____

Please indicate any medical problems not listed above:____
____
____

Please indicate any special precautions: ____
____

Please provide any other information that might help us work with this client: ______________________
____
____

For those with Down Syndrome: AtlantoDens Interval X-rays, date:__________________ Result: + -
Neurologic Symptoms of Atlanto-Axial Instability: ______Present _____Absent

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities and/or therapies. I understand that the PATH International center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH International center (Main Stay Therapeutic Farm, Inc.) for ongoing evaluation to determine eligibility for participation.

Name/Title: ____ MD DO NP PA

Signature: ____ Date: __________________

Address: ____

Phone: ____ License/UPIN Number: ___________