6919 Keystone Road
Richmond IL 60071
815-653-9374
info@mainstayfarm.org

2025 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.

Date:_____

Name: _____ Date of Birth: _____ Age _____

Please indicate current height and weight

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 assisted services)

	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: _____