



# Sundance

*Equine Assisted Therapies*

*There is something about the outside of a horse that is good for the inside of a man.*

*- Winston Churchill*

**Returning Rider Packet**

# Rider Profile

## Tell Us about Yourself

Please fill out this for our rider notebook. The rider notebook is for the volunteers to get to know a little about the riders with whom they will be working.

Date: \_\_\_\_\_

My full name is: \_\_\_\_\_

Please call me: \_\_\_\_\_

My birth date is: \_\_\_\_\_

I started Riding at Sundance Therapies: \_\_\_\_\_

I have \_\_\_\_\_ brothers,  
sisters.

My pets are: \_\_\_\_\_

My interest / hobbies are: \_\_\_\_\_

\_\_\_\_\_

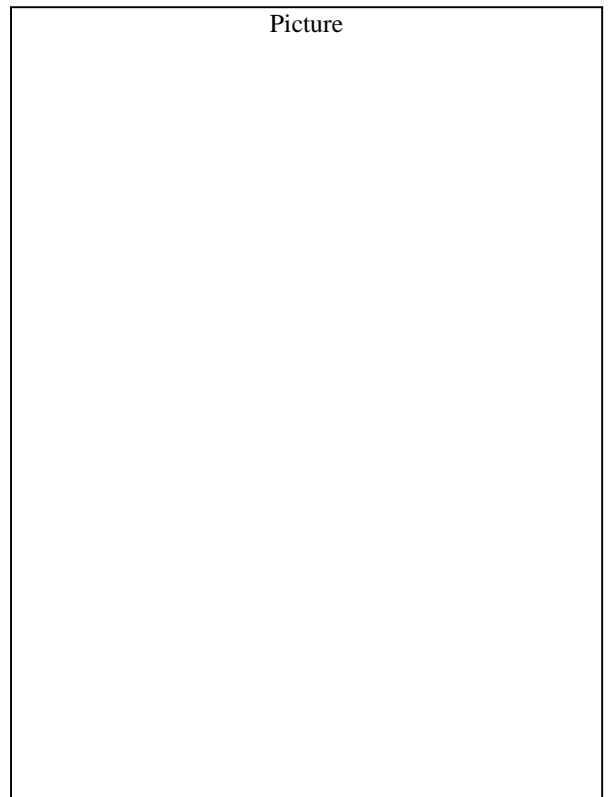
\_\_\_\_\_

My goals for Equine Assisted Therapy are: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Picture



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**Optional:** Please supply any details about the rider you think may be helpful to the volunteers who will be working them.

Speech: \_\_\_\_\_ Comprehension: \_\_\_\_\_

Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Ambulatory Status: \_\_\_\_\_

Other: \_\_\_\_\_

Particular Methods that this rider responds to: \_\_\_\_\_

\_\_\_\_\_



**PHYSICIAN ASSESSMENT & HEALTH HISTORY:**

**~Must be completed by physician~**

Client's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis: Primary: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Secondary: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Other: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Past/Prospective Surgeries (include dates and reasons): \_\_\_\_\_

Seizures:  No  Yes, Type: \_\_\_\_\_ Controlled:  No  Yes, Date of last seizure: \_\_\_\_\_

Medications: \_\_\_\_\_

Shunts Present:  No  Yes, Date of last shunt: \_\_\_\_\_

Implants: \_\_\_\_\_

Mobility: Independent Ambulation:  No  Yes, Assisting Devices: \_\_\_\_\_

***In order to safely provide this service, Sundance Equine Assisted Therapies requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.***

**Orthopedic**

- Atlantoaxial Instability - include neurologic symptoms
- Coxa Arthrosis
- Cranial Deficits
- Heterotopic Ossification/Myositis Ossificans
- Joint subluxation/dislocation
- Osteoporosis
- Pathologic Fractures
- Spinal Joint Fusion/Fixation
- Spinal Joint Instability/Abnormalities

**Neurologic**

- Hydrocephalus/Shunt
- Seizures
- Spina Bifida / Chiari / malformation /Tethered Cord / Hydromyelia

**Other**

- Indwelling Catheters/Medical Equipment
- Medications - i.e. photosensitivity
- Poor Endurance
- Skin Breakdown

**Medical/Psychological**

- Allergies
- Animal Abuse
- Cardiac Condition
- Physical / Sexual / Emotional Abuse
- Blood Pressure Control
- Dangerous to self or others
- Exacerbations of medical conditions (i.e. RA, MS)
- Incidents of Fire Settings
- Hemophilia
- Medical Instability
- Migraines
- PVD
- Respiratory Compromise
- Recent Surgeries
- Substance Abuse
- Thought Control Disorders
- Weight Control Disorder
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

Client's name: \_\_\_\_\_  
**As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply; including surgeries.**

**For those with Down Syndrome:**  
 An Atlantoaxial x-ray and annual exam to exclude Atlantoaxial instability is required for clients with Down Syndrome over the age of 3.      Date of X-Ray: \_\_\_\_\_  
 Results: \_\_\_\_\_  
 Neurologic Symptoms of Atlantoaxial instability: \_\_\_\_\_

Area	No	Yes	Degree/ Comments
Auditory			
Visual			
Speech			
Tactile / Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary / Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other:			

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that Sundance Equine Assisted Therapies will weigh the medical information indicated above against any existing precautions and/or contraindication before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to Sundance Equine Assisted Therapies for ongoing evaluation to determine eligibility for participation.

Name/Title: \_\_\_\_\_ MD, DO, NP, PA Other: \_\_\_\_\_

License/NPI Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**All client records and information are considered confidential and can only be accessed at a staff member's request.**

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, contact Laura Allen, Program Director.

Complete packet and return it to:

Navasota office (1905 Dove Crossing, Ste. AB, Navasota, TX 77868

or you can mail it to Sundance Therapies, Inc. PO BOX 11287, College Station, TX 77842

or you can email it to [info@sundancetherapies.org](mailto:info@sundancetherapies.org)

To be complete and returned for returning riders:

- Session Registration Form
- Rider Profile
- Rider Goals
- Physician Assessment and Health History
- Session Payment

Your paperwork will need to be completed and delivered to Sundance Therapies office PRIOR to your assessment.

*Horses and children, I often think, have a lot of the good sense there is in the world. -  
Josephine Demott Robinson*