Equine-assisted Occupational Therapy
**New Client Form**

**Client information**

Name:______________________________ Date of Birth: _______________Height ______Weight________

Address:______________________________________ State:______ Town: ____________________________

Guardian: ___________________________________ Phone: ___-_____-_______ E-mail:_______________

Diagnosis (list all): ____________________________________________________________________________

Past/Prospective Surgeries: ____________________________________________________________________

Medications (list all): _________________________________________________________________________

Current Therapies (list all):_____________________________________________________________________

Ambulation: Independent Assisted Please list device/ braces ____________

Level of support needed: ____________________________________________________ Glasses: Yes No

Seizures Yes No Date of last seizure ______________ controlled Yes No

For clients with Trisomy 21: Atlantoaxial Instability Present Absent

Other medically necessary information that would exclude this client from participating in equine - assisted activities:

__________________________________________________________________________________________

Given the above listed diagnosis and medical information ____________________________ is not precluded from participating in equine-assisted occupational therapy interventions. I understand that the onsite therapist will weigh the medical information given against existing precautions and contraindications as part of a comprehensive evaluation and therefore will refer this client to Hippocampus. llc for occupational therapy services.

Name/Title: __________________________________________ MD NP DO PA Other: ____________

Address: ______________________________________ State: ______ Town: ______________________

Phone: _________________________________________ License number: __________________________