

Three Gaits, Inc.

Therapeutic Horsemanship Center

MAILING ADDRESS:
P.O. Box 153
Oregon, WI 53575
(608) 877-9086 (office)
3gaits@3gaits.org

PHYSICAL ADDRESS:
3741 Hwy 138W
Stoughton, WI 53589
(608) 873-1929 (fax)
www.3gaits.org



Client Medical History & Physician Release

Client Name _____

Person authorizing release of information (print name if different from rider) _____

(Address, City, State, Zip) (Phone)

Date _____ Signature _____

Primary Diagnosis _____ Date of Onset _____

Secondary Diagnosis _____ Date of Onset _____

Date of Birth _____ Height _____ Weight _____

Past/Prospective Surgeries _____

Shunt Present: Yes No If Yes, date of last revision _____

Seizures: Yes No Controlled: Yes No Type _____ Date of last Seizure _____

Medications: _____

For: _____

Known Allergies _____

Ambulation (circle): Independent Assisted Wheelchair

Incontinence: Yes No Tetanus Shot: Yes No Date _____

Please indicate any special precautions _____

Physician Signature Required - see reverse side

Please provide information about any conditions or surgeries/issues in the following areas.

Is patient challenged in...			If yes, please comment (client/guardian may add information):
Auditory	no	yes	_____
Visual	no	yes	_____
Speech	no	yes	_____
Cardiac	no	yes	_____
Circulatory	no	yes	_____
Pulmonary	no	yes	_____
Neurological	no	yes	_____
Muscular	no	yes	_____
Orthopedic	no	yes	_____
Learning Disability, Emotional/Behavioral Disorder	no	yes	_____

Yes, in my opinion this patient can participate in the Three Gaits, Inc. Therapeutic Horsemanship Program, under appropriate supervision.

No, in my opinion this patient should not participate in the Three Gaits, Inc. Therapeutic Horsemanship Program.

General Comments: _____

Physician's Signature _____ **Date** _____

Physician's Name (please print) _____

Mailing Address _____

Phone _____

Thank you!

PLEASE NOTE: FOR INDIVIDUALS WITH DOWN SYNDROME ONLY

Because of the nature of the horseback riding activity, no individual diagnosed with Down Syndrome can be accepted for riding instruction without proof of a negative diagnostic X-ray for Atlantoaxial Dislocation Condition.

Physician's Acknowledgement:

I have X-rayed this patient for Atlantoaxial Dislocation Condition and the results are negative. In addition this patient does not display signs or symptoms of ADC and may participate in the Three Gaits program.

Date of last X-ray _____

Physician's Signature _____ Date _____

Thank you for your cooperation!

Please return to patient or mail to:

Three Gaits, Inc.

P.O. Box 153

Oregon, WI 53575