SpiritHorse
THERAPEUTIC CENTER
*First Words, First Steps*

**Office Use Only:**

Application Date: ____/_____/_____

# CLIENT APPLICATION

## GENERAL INFORMATION

Applicant Name: _____ Check: ☐ Male ☐ Female

Height: _____ Weight:_____ Date of Birth:___/_____/____

Parent/Legal Guardian: _____ Ethnicity: _____
*Not required; for grant application purposes only.*

Phone: (Home) _____ (Cell) _____ (Work) _____

Address: _____ City:_____ State:____ Zip Code:_____

County: _____ E-Mail:_____
*Used for notification, newsletters, etc.*

Name of Current School: _____

Referral Source: _____

Name of Your Employer: _____
*Used for grant application purposes*

****Every applicant must have page 1-6 completed along with a doctor signed diagnosis to be put on our waiting list or to start therapy sessions**.

If the applicant is a Victim of Abuse, Battered Women, or an At-Risk Youth, this does not apply.

Is the applicant a Victim of Abuse, Battered Women, or an At-Risk Youth? ☐ Yes ☐ No

## SCHEDULING INFORMATION

**HOURS: MON. – FRI. 12:30 PM – 7:00 PM, SAT. and SUN. 8 AM- 5PM (Extended hours in the summer) EACH STUDENT CAN RIDE ONE TIME PER WEEK ON THE SAME DAY, AND AT THE SAME TIME; EACH LESSON LASTS FOR 30 minutes Mounted (on the Horse) and 30 minute and 1 hour dismounted lesson include grooming and saddling the horse.**

**For scheduling purposes, please fill in ALL the times you or your child will be available to ride on each day. Please keep in mind that weekend and after school hours are our busiest times. (We will choose one day and time for you or your child to ride on a weekly basis)**

Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____

## APPLICANT HEALTH HISTORY

***Please indicate current/past problems in the following areas (Please include triggers, if any):***

Vision: _____

Hearing: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Emotional: _____

Behavioral: _____

Pain: _____

Bone/Joint: _____

Muscular: _____

Thinking/Cognitive: _____

Allergies: _____

Current Medications of Applicant (over-the counter included):

_____

_____

_____

Please describe applicant's FUNCTIONAL abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

_____

_____

*Please describe assistance required or equipment needed:

_____

_____

Please describe applicant's SOCIAL abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

*Please describe assistance required or equipment needed:

_____

_____

## APPLICANT INFORMATION

Goals (reason for applying; what would you like to see accomplished):

_____

_____

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings) (Dislikes: pets, sounds, etc.):

_____

_____

_____

What types of things work best for the applicant in terms of rewards and motivation?

_____

_____

_____

How does the applicant best communicate with others?

- ☐ Spoken Language
- ☐ Sign Language ☐ASL ☐E/E
- ☐ Written Language
- ☐ Communication device
- ☐Combination of the above (please describe)

_____

Does the applicant use:

- ☐ Echolalia (repeating words without regard for meaning)

- ☐ Stemming (rocking, spinning, hand flapping)
- ☐ Self Regulatory Behavior (Please describe how the applicant uses this self soothing behavior):

_____

Do changes in the applicant's environment affect their behavior?

☐ Never ☐ Sometimes ☐ Frequently

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Applicant's Name: _____ Date of Birth: ____/____/_____Phone: (___)_____

Applicant's Address: _____ City: _____ State:____Zip Code:_____

Medical Facility:_____ Phone: (_____)_____

Physician's Name:_____ Phone: (_____)_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

_____

Current Medications: _____

_____

**Emergency Contacts**:

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

In the event emergency medical aid /treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize SpiritHorse Therapeutic Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

*(Please sign the CONSENT PLAN or the NON-CONSENT PLAN on next page)

# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

**Consent Plan**

I ***DO*** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ Date: ____/_____/_____

**If under 18 years of age, parent/guardian signature required below**.

Signature: _____ Date: ____/____/_____

**Non-Consent Plan**

I ***DO NOT*** give my consent for emergency medical treatment aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment aid is required; I wish the following procedures to take place:

_____

_____

_____

Signature: _____ Date: _____/_____/_____

**If under 18 years of age, parent/guardian signature required below**.

Signature: _____ Date: ____/_____/_____

# PHOTO AND VIDEO CONSENT

I, _____ consent_____ or **do not** consent_____ to authorize the use and reproduction by SpiritHorse Therapeutic Center of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Signature: _____ Date: _____/_____/_____

**If under 18 years of age, parent/guardian signature required below**.

Signature: _____ Date: _____/_____/_____

# SPIRITHORSE THERAPEUTIC RIDING CENTER

## RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date _____/_____/_____ and for thereafter between Cheryl P. Cleaves (Executive Director) and SpiritHorse Therapeutic Riding Center of Canton and _____ (The Participant); and, if Participant is a minor, their Parent or Legal Guardian _____. In return for use, today and on future dates, of the property, facility and services of the Executive Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his/her horse if he/she owns or leases one, personal property, and him/herself.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence Upon SpiritHorse Therapeutic Center, and the Executive Director's Property And Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
3. Participant agrees to hold SpiritHorse Therapeutic Center, the Executive Director and all its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon SpiritHorse Therapeutic Center, and the Executive Director's property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.
5. Participant agrees to indemnify and defend SpiritHorse Therapeutic Center and the Executive Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon SpiritHorse Therapeutic Center and the Executive Director's property or facility.
6. Participant agrees to abide by all of SpiritHorse Therapeutic Center's and the Executive Director's safety rules and regulations.
7. If Participant is using his/her horse, the horse shall be free from infection, contagious or transmittable disease. SpiritHorse Therapeutic Center and the Executive Director reserve the right to refuse horse if not in proper health, or is deemed dangerous or undesirable.
8. This contract is non-assignable and non-transferable, and is made and entered into in the State of Connecticut, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When SpiritHorse Therapeutic Center, the Executive Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.
9. Warning: Under Connecticut law, an Equine Professional is not liable for an injury to and/or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Signature: _____ Date:____/_____/_____

**If under 18 years of age, parent/guardian signature required below**.

Signature:_____ Date:____/_____/_____

## PHYSICIAN'S PRESCRIPTION

*(To be filled out by physician only)*

Dear Physician:

Your patient _____ is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

**ORTHOPEDIC**

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability /Abnormalities

**NEUROLOGIC**

Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

**OTHER**

Indwelling Catheters
Medications - i.e. photosensitivity
Skin Breakdown

**MEDICAL/PSYCHOLOGICAL**

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

*Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below. Sincerely, SpiritHorse Therapeutic Riding Center*

## Physician's Prescription

Client's Name: _____ Phone: (_____) _____

**Prescription for Therapeutic Horseback Riding**

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with SpiritHorse Therapeutic Center.

Recommended Frequency:

Precautions:

Physician's Signature: _____ Date: ____/_____/_____

Return To:
SpiritHorse Therapeutic Riding Center of Canton, Inc. 174 Morgan Road, Canton, CT 06019
(860) 841-9930
email: SpiritHorseCT@yahoo.com

## MEDICAL HISTORY & PHYSICIAN'S STATEMENT

*(To be filled out by physician only)*

Applicant Name:_____ Male☐ Female ☐ Date of Birth:___/_____/_____

Height:_____ Weight:_____ Diagnosis:_____

Date of Onset: ____/_____/_____ Past/Prospective Surgeries:_____

Medications: _____

Seizure Type: _____ Controlled: ☐ Yes ☐ No Date of Last Seizure: ____/_____/_____

Shunt Present: ☐ Yes ☐ No Date of Last Revision: ____/_____/_____

Special Precautions/Needs: _____

**Mobility**:

Independent Ambulation: ☐ Yes ☐ No Wheelchair: ☐ Yes ☐ No

Assisted Ambulation: ☐ Yes ☐ No Braces/Assistive Devices: _____

**For Those With Down Syndrome**:

AtlantoDens Interval X-Rays, Date: ____/_____/_____ Results: _____

Neurologic Symptoms of AtlantoAxial Instability:_____

**PLEASE INDICATE CURRENT/PAST DIFFICULTIES IN SYSTEMS/AREAS; INCLUDE SURGURIES:**

**Auditory**:_____
**Visual**: _____
**Tactile Sensation**: _____
**Speech**: _____
**Cardiac**: _____
**Circulatory**: _____
**Integumentary/Skin**: _____
**Immunity**: _____
**Pulmonary**: _____
**Neurologic**: _____
**Muscular**: _____
**Balance**: _____
**Orthopedic**: _____
**Allergies**: _____
**Learning Disability**: _____
**Cognitive**: _____
**Emotional**: _____
**Pain**: _____
**Other**: _____

**To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above, against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.**

Name/Title:_____ License/UPIN #:_____

Signature:_____ Date:_____/_____/_____

# PHYSICAL/OCCUPATIONAL THERAPY QUESTIONNAIRE

*(To be filled out by therapist only)*

Client Name: _____ DOB: ____/___/_____ Age:_____

Address: _____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

**Physical/Occupational Therapist (Please Sign)** **Date**

Return To:
SpiritHorse Therapeutic Riding Center of Canton, Inc.
174 Morgan Road, Canton, CT 06019
(860) 841-9930
email: SpiritHorseCT@yahoo.com

# SPECIAL EDUCATION TEACHER QUESTIONNAIRE

*(To be filled out by special education teacher only)*

Client Name: _____ DOB: ____/___/_____ Age:_____

Address: _____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Cognitive and/or Behavioral Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

**Special Education Teacher (Please Sign)** **Date**

Return To:
SpiritHorse Therapeutic Riding Center of Canton, Inc.
174 Morgan Road, Canton, CT 06019
(860) 841-9930
email: SpiritHorseCT@yahoo.com

# BEHAVIORAL THERAPY QUESTIONNAIRE

*(To be filled out by therapist only)*

Client Name: _____ DOB: ____/___/_____ Age:_____

Address: _____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Behavioral Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

**Behavioral Therapist (Please Sign)** **Date**

Return To:
SpiritHorse Therapeutic Riding Center of Canton, Inc.
174 Morgan Road, Canton, CT 06019
Phone (860) 841-9930 email: SpiritHorseCT@yahoo.com

# SPEECH THERAPY QUESTIONNAIRE

*(To be filled out by therapist only)*

Client Name: _____ DOB: ____/___/_____ Age:_____

Address: _____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for Therapeutic Horseback Riding Sessions at SpiritHorse. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Speech Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Oral Motor Activities:

Any Helpful Hints for Working with This Person:

_____ _____/_____/_____

**Speech Therapist (Please Sign)** **Date**

Return To:
SpiritHorse Therapeutic Riding Center of Canton, Inc.
174 Morgan Road, Canton, CT 06019
(860) 841-9930 email: SpiritHorseCT@yahoo.com www.SpiritHorseCT.org