CAPITAL AREA THERAPEUTIC RIDING ASSOCIATION

Post Office Box 339, Grantville, PA 17028-0339 (717) 469-7517 *www.catra.net*

STUDENT MEDICAL HISTORY: TO BE COMPLETED BY A PHYSICIAN

NAME:_____ DATE: _____ PHONE:_____

Age: _____ Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Physically Handicapped: YES_____ NO_____ Mentally Retarded: YES_____ NO_____

Emotionally Disturbed: YES_____ NO_____ Learning Disabled: YES_____ NO_____

DIAGNOSIS: _____

Cause: _____Onset: _____

Limbs affected: _____

If spinal cord involvement, what vertebral level: _____

If Downs Syndrome, Atlanto-Axial subluxation? Yes_____ No_____

Cervical x-ray for Atlanto-Axial subluxation: Positive_____ Negative_____

Estimate of mental ability: _____

Please indicate if the student has any of the following secondary problems by checking yes or no. If yes, please include complete information pertaining to the problem.

PROBLEM	YES	NO	If yes, describe
VISUAL			
HEARING			
SPEECH			
CARDIAC			
			Pulse: Blood Pressure:
CIRCULATORY			
Peripheral Vascular Dis.			
Hemophilia			
PULMONARY			
METABOLIC/G.I. G.U.			
Diabetes			
Bladder/Bowel control			
SKIN and SOFT TISSUE			
Pressure sore			Healed (Yes No) Location
SURGERY			Date:
PAIN			
MEDICATION			

MEDICAL HISTORY

PROBLEM	YES	NO	If yes, describe
NEUROLOGICAL			
Seizures			Controlled (Yes No) Last Seizure
			Type
Hydrocephalus			Shunt (Yes No)
Sensory Loss			
MUSCULAR			
Contractures			
SKELETAL			
Subluxing hips			
Dislocating hips			
Spinal Laminectomy			
Scoliosis			Degree, type, last x-ray
Kyphosis, Lordosis			Degree, type
Spondylosis			
Spondylolisthesis			
Osteoporosis			
Heterotrophic Ossific.			
Arthrodesis			
Fractures			Healed (Yes No) Location
OTHER or SPECIAL PRECAUTIONS			

MOBILITY STATUS:

Can the student ambulate? Yes ❑ No ❑

Assistance: Independent _____ Minimal _____ Moderate _____ Maximal _____

1 person assist _____ 2 person assist _____

Physical aids: Canes _____ Crutches _____ Walker _____ Rolling Walker _____

Braces (type) _____

Other (ie. splints) describe _____

Does the student use a wheelchair? Yes ❑ No ❑ Type of w/c _____

Can the student propel the wheelchair? _____

Please describe any other additional information that might help us to work with this student. Thank you for your time.

Physician's Signature : _____ M.D. Date_____

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