Limitless Riders
Therapeutic Riding Registration

REGISTRATION:

Client: ____ Date of Birth: _____/_____/________

Diagnosis:____ Seizures: ____________

Age: ______________________ Height: ______________________ Weight: ____________________

Street Address: ____

City: ____ State: __________ Zip: __________

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Parent or Guardian: ____

Email address: ________________ Best communication method: ❒ Phone, ❒Email, ❒FB Message

Emergency Contact: _______________________________________ Phone: ___________________
(other than guardian above).
Other: ____ Phone: __________________

How do you hope your child will benefit from the therapeutic horseback riding program?

____

____

____

Has your child had any previous horseback riding experience?

❒ Yes ❒ No

What else would you like us to know about your child?

____

____

____

____

© Limitless Riders

MOTOR FUNCTION:

Mobility

☐ Able to walk normally without assistance or special devices.

☐ Requires assistance or special devices. Please describe specifically:

____

____

____

Transfers:

☐ No assist needed.

☐ Transfers with

- ☐ Assist of 1
- ☐ Assist of 2
- ☐ Assist of 3 or more

There are structural problems or absence of the following body parts:

____

Are there any joints limited in range of motion/mobility? (describe):

____

____

My child is able to do the following by him/herself without special support:

☐ Roll

☐ Belly Crawl

☐ Stand by furniture

☐ Sit on chair

☐ Sit on floor

☐ Creep on hands and knees

☐ Stand without support

☐ Climb stairs

☐ No impairment

☐ Knee walk

☐ Walk

Please describe specifically:

____

Describe any operations your child has had.

____

____

© Limitless Riders

BEHAVIOR:

My child's response to a new situation or new people is:

- ☐ Open and receptive
- ☐ Resistive or fearful
- ☐ Warms up gradually
- ☐ Passive, little response
- ☐ Hesitant

My Child ❐ Has no special fears
❐ Fears the following: ______________________________

COMMUNICATION SKILLS:

Communicates to others by:

- ☐ Speaking in sentences
- ☐ Using 1-2 word phrases
- ☐ Uses alternative means of communication ❐pointing ❐sign language ❐looks at objects ❐language boards, etc. Describe:

____

____

____

She/he learns best ❐ By most common teaching methods
❐ In a few, select ways

Describe: ______________________________

____

____

She/he understands:

- ☐ Complex directions
- ☐ Simple directions
- ☐ Single Words
- ☐ Sign language for the deaf
- ☐ Has delayed response to directions

SEIZURES:

- ☐ Has never been a problem for him/her.
- ☐ Were seen in the past but not in the last two years
- ☐ Are controlled by medication
- ☐ Are not completely controlled

Describe type, frequency, and management: ______________________________

____

MEDICATIONS:

- ☐ Takes no medications.
- ☐ Takes the following medications: ______________________________

© Limitless Riders

ALLERGIES:

☐ Pollen ☐ Food ☐ Other: __________
☐ Mold ☐ Medication ☐ No known allergies
☐ Insect Stings ☐ Latex

Please describe (allergy/type of reaction, solution): ____

____

____

____

HAND FUNCTION:

☐ No impairment

☐ Function is impaired as describe below:

The hand my child uses best is: ❐ Right ❐ Left

Style uses: ❐ One hand much better than the other

❐ Both hands about the same.

Would your child be able to pick up an object as small as a raisin with his/her thumb and fingertip?

❐ Yes ❐ No

Does your child have a special problem with brittle bones or fractures?

❐No

❐Yes (describe) ____

____

VISION AND HEARING:

Vision Skills:

☐ Normal

☐ Impaired

- ☐ Corrected with glasses
- ☐ Legally blind
- ☐ Cortical blindness
- ☐ Other (describe): ____

____

Hearing Skills:

☐ Normal

☐ Impaired (indicate degree): ____

☐ Hearing Aid

Parent/Guardian Signature____ Date: ____/____/________

© Limitless Riders