Stable Hands
Equine Therapy Center
V.A.S.T. | Veterans Assisted Sports Training

ASSESSMENT FORM

TODAY'S DATE:_____

CLIENT INFORMATION

FIRST NAME:_____MIDDLE INITIAL: _____LAST NAME: _____

ADDRESS: _____

HOME/CELL PHONE:_____ WORK PHONE: _____

DOB: _____ AGE:_____ HEIGHT:_____ WEIGHT:_____ GENDER: M F (circle one)

ARE YOU EMPLOYED? Y N (circle one)

EMPLOYER:_____

ADDRESS:_____PHONE:_____

HOW DID YOU HEAR ABOUT THE PROGRAM?_____

FAMILY INFORMATION

SPOUSE/GUARDIAN/CARETAKER (circle which one) NAME: _____

ADDRESS: _____

HOME/CELL PHONE:_____ WORK PHONE: _____

EMAIL: _____

FAMILY MEMBER'S NAME: _____ AGE: ____ SEX: __ RELATION:_____

FAMILY MEMBER'S NAME: _____ AGE: ____ SEX: __ RELATION:_____

FAMILY MEMBER'S NAME: _____ AGE: ____ SEX: __ RELATION:_____

FAMILY MEMBER'S NAME: _____ AGE: ____ SEX: __ RELATION:_____

MILITARY INFORMATION

MILITARY BRANCH:_____ RANK: _____

SERVICE DATES: _____ # OF YEARS: _____

DEPLOYMENTS:_____

WHAT WOULD YOU LIKE TO GAIN FROM THIS EXPERIENCE?

TELL US YOUR STORY (use back side of this sheet if more room is needed)

ISSUES YOU'RE STRUGGLING WITH

- o Drug & Alcohol
- o Anxiety
- o History of Incarceration
- o PTSD
- o Other
- o Verbally Aggressive
- o Physically Aggressive
- o Destructive to Property
- o ADHD
- o Depression
- o Suicidal Tendencies
- o Eating Disorders
- o Medical Concerns
- o Physically Abused/Abusive
- o Emotionally Abused/Abusive
- o Sexually Abused/Abusive
- o Self Abuse

PLEASE EXPAND: _____

MENTAL AND PHYSICAL HEALTH DIAGNOSIS (Include any assistance required or equipment needed)

MEDICATIONS & REASON PRESCRIBED

Medication:_____ Reason:_____

Medication:_____ Reason:_____

Medication:_____ Reason:_____

Medication:_____ Reason:_____

Medication:_____ Reason:_____

NOTABLE TRAUMAS OR EVENTS

TRIGGERS (If known)

BEHAVIORS RESULTING FROM TRIGGERS (If known)

PHOTO RELEASE:

I □ DO □ DO NOT

consent to and authorize the use and reproduction by Stable Hands Equine Therapy Center of any and all photography and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

SIGNATURE:_____ DATE:_____

LIABILITY RELEASE

_____(Rider's name) would like to participate in the Stable Hands program. I acknowledge the risks and potential for risks of horseback riding and horse related activities. However, I feel the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Stable Hands, Inc., its Board of Directors, Instructors, Therapist Consultant, Equine Manager/Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the Stable Hands program.

Notice: A person who is engaged for compensation in the rental of equines or equine equipment or tack or in the instruction of a person in the riding or driving of an equine or in being a passenger upon an equine is not liable for the injury or death of a person involved in equine activities resulting from the inherent risks of equine activities, as defined in section 895.481(1)(e) of the Wisconsin Statues.

SIGNATURE:_____ DATE:_____

RIDER'S AUTHORIZATION/EMERGENCY MEDICAL TREATMENT

In the event of an 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 Stable Hands to;

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

IN CASE OF AN EMERGENCY CONTACT:

CONTACT #1_____ RELATIONSHIP:_____ PHONE:_____

CONTACT #2_____ RELATIONSHIP:_____ PHONE:_____

PHYSICIAN'S NAME: _____

PREFERRED MEDICAL FACILITY: _____

HEALTH INSURANCE COMPANY: _____

POLICY#: _____

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

DATE:_____ PRINT NAME: _____

SIGNATURE:_____

3501 Swan Ave • Wausau, WI 54401 • 715.359.6046 • dabitz@stablehandstherapy.com

PARTICIPANT'S CONSENT FOR RELEASE

I hereby authorize: _____
(person or facility)

to release information from the records of: _____ DOB: _____
(participant's name)

The information is to be released to: Stable Hands Equine Therapy Center
(center or therapist's name)

for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:

- □ Medical history
- □ Physical therapy evaluation, assessment and program plan
- □ Speech therapy evaluation, assessment and program plan
- □ Mental health, psychosocial evaluation
- □ Other:

This release is valid for one year and can be revoked, in writing, at my request.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

RELATION TO PARTICIPANT: _____

PLEASE SEND MATERIALS TO:

Stable Hands Equine Therapy Center
Mailing address: 3501 Swan Ave.
Wausau, WI 54401

Or email to: dabitz@stablehandstherapy.com

Stable Hands Equine Therapy Center
V.A.S.T. | Veterans Assisted Sports Training
3501 Swan Ave • Wausau, WI 54401 • 715.359.6046 • dabitz@stablehandstherapy.com

Date:_____

Dear Health Care Provider,

Your patient: _____is interested in participating in supervised equine activities.
(participant's name)

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC
Atlantoaxial Instability - include neurologic symptoms
Coxarthrosis
Cranial Defects
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

NEUROLOGIC
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation\Tethered Coed/Hydromyelia

OTHER
Indwelling Catheters/Medical Equipment
Medications- e.g., Photosensitivity
Poor Endurance
Skin Breakdown

MEDICAL/PSYCHOLOGICAL
Allergies Animal
Abuse Cardiac
Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to Self or Others
Exacerbations of Medical Conditions (e.g., RA, MS)
Fire Setting
Hemophilia
Medical Instability
Migraines
PVD
PTS
MTS
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact the center at the address/phone indicated above.

Sincerely,

Diane Abitz, Program Director
Stable Hands Equine Therapy Center
715.359.6046