



CLIENT APPLICATION

OFFICE USE ONLY:

VOCA 421 VAWA D YAD

Application Date: _____

GENERAL INFORMATION

Applicant Name: _____ 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: _____ E-Mail: _____
Used for notification, newsletters, etc.

Name of Current School: _____ Referral Source: _____

Name of Parent/Guardian/Applicant Employer: _____
Used for grant application purposes

Number of People in Household: _____

SCHEDULING INFORMATION

*DURING SESSION, NORMAL LESSON TIMES ARE MON. - SUN. FROM 8:00 AM - 7:00 PM
EACH STUDENT RIDES ONE TIME PER WEEK ON THE SAME DAY, AND AT THE SAME TIME; EACH LESSON LASTS FROM
30 MIN. - 1 HR.*

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 weekends 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: _____ Friday: _____

Tuesday: _____ Saturday: _____

Wednesday: _____ Sunday: _____

Thursday: _____

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:



HEALTH HISTORY (CONT.)

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)
- Stimming (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

Name: _____ Date of Birth: _____

Phone: _____ 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: _____





RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date _____ and for thereafter between Charles I. Fletcher (Executive Director) and SpiritHorse Therapeutic Center 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 horse if he owns or leases one, personal property, and himself.
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 it's 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 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 Texas, 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 Texas law (Chapter 87 Civil Practice and Remedies code) 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: _____

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 Assisted Ambulation: Yes No

Wheelchair: 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: _____

PHYSICIAN'S PRESCRIPTION

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 Center, 1960 Post Oak Drive, Corinth, Texas 76210 (940) 497-2946
www.spirithorsetherapy.com

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 Center, 1960 Post Oak Drive, Corinth, Texas 76210 (940) 497-2946
www.spirithorsetherapy.com

SPECIAL EDUCATION TEACHER 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 Cognitive and/or Behavioral Needs to Address:

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

Recommended Activities:

Any Helpful Hints for Working with This Person:

Special Education Teacher (Please Sign)

Date

Return To:
SpiritHorse Therapeutic Center, 1960 Post Oak Drive, Corinth, Texas 76210 (940) 497-2946
www.spirithorsetherapy.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:

Therapist (Please Sign)

Date

Return To:
SpiritHorse Therapeutic Center, 1960 Post Oak Drive, Corinth, Texas 76210 (940) 497-2946
www.spirithorsetherapy.com

SPEECH THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

Client Name: _____ DOB: _____ Age: _____

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 Center, 1960 Post Oak Drive, Corinth, Texas 76210 (940) 497-2946
www.spirithorsetherapy.com

DIRECTIONS TO SPIRITHORSE

From the Lewisville area:

Go north on I-35 towards Denton. Exit Shady Shores Road/Post Oak Drive. (We are the 5th exit after you cross Lake Lewisville and is also exit for Bill Utter Ford). Turn left across the bridge to go west on Post Oak. Go straight for one mile. You will see black board fencing on the left and at a break in the fencing there are two driveways, side by side. Take the second drive. There is a small black SpiritHorse Sign at the road.

From Plano:

Go west on Hwy 121 to I-35 in Lewisville. Follow directions from Lewisville, above.

From Denton:

Go south on I-35 towards Dallas. Take the Post Oak Drive/ Shady Shores exit, which is the second exit past the Golden Triangle Mall. Turn right on Post Oak. Go straight for one mile. You will see black board fencing on the left and at a break in the fencing there are two driveways, side by side. Take the second drive. There is a small black SpiritHorse Sign at the road. The address is 1960 Post Oak Drive, Corinth, Texas 76210.

From Argyle:

From Hwy 377, turn right (east) on Hwy 407. Turn left on FM 1830. Turn right on Hickory Hill. Turn left on Hilltop Rd. Ignore Hilltop as it turns left, continue straight (this is Old Alton Road, which is unmarked). Follow to a "T", and turn left on Old Alton Road. At the first stop sign, turn right on Teasley (FM 2181). Turn left on Post Oak Dr. (immediately before a vet clinic). Go thru stop sign, continue ½ mile, SpiritHorse will be on your right. There is a small black SpiritHorse Sign at the road.

SpiritHorse Therapeutic Center

1960 Post Oak Drive
Corinth, Texas 76210
(940)497-2946
(940)497-4439 fax
info@spirithorsetherapy.com
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