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 1-7 completed along with a doctor signed diagnosis (page 8 & 9) to be put on our waiting list**.

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

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 1 HR. (including grooming and tacking up)

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: _____

APPLICANT HEALTH HISTORY (continue)

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
- ☐ Written Language
- ☐ Sign Language ☐ASL ☐E/E
- ☐ 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 Rehabilitation 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 Rehabilitation 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 REHABILITATION CENTER

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 Rehabilitation 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/her horse if he/she owns or leases one, personal property, and him/her self.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence upon SpiritHorse Rehabilitation 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 Rehabilitation 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 Rehabilitation 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 Rehabilitation 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 Rehabilitation Center and the Executive Director's property or facility.
6. Participant agrees to abide by all of SpiritHorse Rehabilitation 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 Rehabilitation 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 Rehabilitation 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:____/_____/_____

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 Rehabilitation 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 Rehabilitation Center.

Recommended Frequency:

Precautions:

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

Return To:
SpiritHorse Rehabilitation Center, 10363 Fort Davis Trail, San Antonio, Texas 78245
(210) 593-8274

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 Rehabilitation 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 Rehabilitation Center
10363 Fort Davis Trail, San Antonio, Texas 78245
(210)593-8274

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 Rehabilitation Center
10363 Fort Davis Trail, San Antonio, Texas 78245
(210)593-8274

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 Rehabilitation Center
10363 Fort Davis Trail, San Antonio, Texas 78245
(210)593-8274

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 Rehabilitation Center
10363 Fort Davis Trail, San Antonio, Texas 78245
(210)593-8274
www.spirithorsetherapy.com email: brandi.spirithorse@gmail.com

DIRECTIONS TO SPIRITHORSE

From the Lewisville area:

- Go north on I-35E 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-35E in Lewisville. Follow directions from Lewisville, above.

From Denton:

- Go south on I-35E 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.

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.

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