LITTLE BIT THERAPEUTIC RIDING CENTER
MEDICAL UPDATE FORM

In order to provide the highest quality of services and safety to all our clients, it is vital that our records are updated with any changes in the client's medical history. Additionally, we would like to hear about new goals that the client may have. **Please complete ALL sections.**

Date Form Completed: _____

Person completing this form:_____Relationship: _____

Rider/Patient Name: _____

Diagnosis: _____

Secondary diagnosis: _____

DOB: _____ Age: _____ Weight: _____ Height: _____ Gender: _____

If diagnosed with Down Syndrome, please tell us the last time you had a Cervical X-Ray for Atlanto-Axial Subluxation
X-Ray Date:_____ Please check if the X-Ray was Negative:_____or Positive:_____

Over the last 12 months has the rider/patient:

Had any changes in diagnosis: Yes_____ No _____ If yes, please describe any changes:

Seen a primary doctor: Yes_____ No _____ If yes, please describe any changes:

Seen an orthopedist, neurologist, pediatrician, etc: Yes_____ No____ If yes, please describe any changes:

Had any medication changes? Yes _____ No ____ If yes, what has changed (side effects)?

Received any other therapies? Yes _____ No _____ If yes, what and how often?

Had any increase or decrease in seizure activity? Yes _____ No _____ If yes, please describe:

What new goals do you/your rider have for your lessons?

Are there any concerns or questions that you would like to discuss with your instructor? Please let us know and provide a suitable day and time for a return phone call or email address for follow up.