



Disabilities Assessment Guide

Name of Rider: _____ Date of Birth: _____

Male Female

ADHD/ADD:	Learning Disabilities:
Amputations:	Mental Retardation:
Autism:	Multiple Sclerosis:
Brain injuries:	Muscular Dystrophy:
Cardiovascular accident/Stroke:	Spinabifida:
Cerebral Palsy:	Spinal Cord injuries:
Down Syndrome:	Victims of Abuse:
Emotional Disabilities:	Visual Impairment:
Hearing Impairment:	Other:

Primary care physician:	Equine Therapy Approval on file?	Yes No	Allergies:
Phone#			
Special needs:			

Guardian signature stating the above information is true to the best of your knowledge:

X _____ Date/Time: _____

Guardian/Relationship: _____

Open Arms Therapy Approval signature: _____ Date/Time: _____