The National Center for Equine Facilitated Therapy

880 Runnymede Road
Woodside Ca 94062
Phone - (650)851-2271
Fax - (650)851-3480

- Screening Form -

Date: _____

Patient Name: _____ DOB: _____ Age: _____ Gender: ____M / F

Parent or Guardian (if Minor): _____ Patient's Diagnosis: _____

Address: _____

Phone: _____ Email: _____

Motor Skills: please circle yes or no

1. Can the patient hold his/her head in the middle of her body? Yes No
    a. If yes, how long? _____
2. Can the patient sit by his/herself? Yes No
    a. If yes, do they prop on their hands to maintain sitting? Yes No
3. Can the patient pull to stand? Yes No
4. Can the patient crawl? Yes No
5. Can the patient walk? Yes No
    a. Do they use an assistive device? Yes No
        i. If yes, what? _____
    b. Do they wear any braces on their legs or feet? Yes No
        i. If yes, what? _____

Medical History (please check yes or no, if yes please comment with additional information)

Orthopedic	Yes	No	Comments
Acute herniated disc			
Degeneration of the hip			
Spondylolisthesis (*spon-dylol-isthe'sis*)			
Spinal fusions (organic or operative)			
Scoliosis greater than 30 degrees			
Unstable spine or history of subluxation			
Hip Subluxation			
Medical			
Acute stage of arthritis			
Atlanto - axial instability			
Anti - coagulation medication			
Exacerbation of multiple sclerosis			
Hemophilia			
Open pressure sores			
Severe osteoporosis			
Uncontrolled seizures			
Medication that change alertness			
History of an aneurysm			
Tethered cord or chiari (*ki-ar-ee*) II malformation associated with spina bifida cystica			

Other	Yes	No	Comment
Achondroplasia (short stature)			
Arthrogryposis (*arthro-grip-osis*)			
Significant Allergies to dust, horse hair or hay			
History of skin break down or skin grafting over weight bearing surfaces			
High level spinal cord paralysis or significant muscular asymmetries			
Recent surgery			
Serious heart condition			
Ongoing upper respiratory infection or chronic pneumonia			
Behavioral outbursts that pose a danger to themselves or others			
Heterotrophic ossification or myositis ossifcans			
Osteogenesis imperfecta			

Please tell us 3 things you think the patient does very well and 3 things you'd like them to work on here:

_____

_____

_____

_____

How did you hear about us? _____

Current Services:

Service	Yes	No	How often?	Where?
School				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Other				

Does your child have any experience with animals? If so, what? _____

_____

NCEFT is a non-profit organization. We provided financial scholarships, based on need and a sliding scale. Third party payors (insurance companies) are not billed for PT, OT, or SLP services by NCEFT. Any pre-authorizations, advocacy or follow up with carriers are the responsibility of the insured. How much, if any of our services will be covered depends on the individual policy

OFFICE USE:
Reviewed By: _____ Date: _____
Patient is appropriate for an evaluation with : PT ___ OT ___ SLP ___ AR___
Patient is not appropriate for hippotherapy at this time because _____

_____