



**RIDER PROFILE AND
REGISTRATION FORM**

Client: _____ Date of birth: _____

Age: _____ Height: _____ Weight: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Home Phone: (____)_____, Work phone: (____)_____, Cell: (____)_____

Email address: _____

Parent(s) or Guardian(s): _____

Address: _____

(if different from above)

Emergency Contacts

Name: _____ Phone: (____)_____, (____)_____

Relationship to rider: _____

Name: _____ Phone: (____)_____, (____)_____

Relationship to rider: _____

Information is kept confidential and reviewed by the RTRA's Medical Advisor, Physiotherapist and Instructor/ Instructors for a Therapeutic Riding Program assessment.

Answering the following questions will enable us to design a personal riding program that will ensure the rider's safety as well as the Instructor and volunteers. Goals are achieved with better understanding of the rider's capabilities.

a) Diagnosis:

b) Pertinent medical history or conditions such as: diabetes, seizures, incontinence, communicable diseases, allergies, etc.

- c) Please list any medications (Prescription and non-prescription.)
- d) Impairments such as: hearing, vision, speech, sensation or attention?
- e) Behavior problems, fears or social interaction issues?
- f) Please describe the rider's personality.
- g) Motor skills, balance and coordination. Able to sit or stand independently?
- h) Please describe any muscle tone, strength or flexibility concerns in both upper and lower extremities.
- i) Is the rider's developmental level considered appropriate for his/her age? If not, please explain.
- j) List any goals that you would like to achieve while participating in our therapeutic riding program.

Client/Parent _____
(please print)

Date _____

Signature _____