WE CAN RIDE

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Date Received _____

2019 Scoliosis Form

Orthopedic Physician Signature Required

Return to office

The following client has requested to participate in horseback riding activities with our program. These activities may include walking and/or trotting while on horseback, which can produce compression forces in the spine. Due to their diagnosis of scoliosis, we want to be sure that horseback riding activities are appropriate for this client. Our guidelines suggest that anyone with a spinal curvature > 30 degrees requires additional caution and physician approval. *Please* indicate the 1) degree of curvature this client has, 2) if there are any precautions you would like us to follow and 3) if it is appropriate to participate in our program.

Client Name:_____**Date of Exam**:_____

Area of Curvature:

Thoracic ☐ Degree of Curve:_____
Overall affect:_____
_____
_____

Lumbar ☐ Degree of Curve:_____
Overall affect:_____
_____
_____

If any precautions please list here:_____
_____
_____
_____

In my opinion, this patient can receive horseback riding under appropriate supervision. However, I understand that *We Can Ride, Inc*. will determine whether they can safely provide services.
Physician
Name(Print):_____Signature:_____
Date:_____ Stamp Address Here:
Address:_____
City/State/Zip_____
Phone:_____
E-mail:_____