

Medical history and information				
	Yes	No	Age	Describe
Meningitis				
Encephalitis				
Fever				
Convulsions				
Allergies to:				
• Dairy products				
• Starch/carbohydrates				
• Preservatives				
• Colorants				
To be completed by riders doctor (if applicable):				
1. Diagnosis of rider:				
2. Details of specific disability:				
Rider profile				
To be completed by rider or the person responsible of his/her care. This information will help with the allocation of a suitable horse/pony and identify the need for helpers				
Height:		Weight:		
Please circle the applicable condition:				
1. Visual problems		Yes		No
2. Hearing problems		Yes		No
3. Speech problems		Yes		No
4. Inability to understand verbal instructions		Yes		No
5. Self care:				
• Independent		Yes		No
• Requires help		Yes		No
• Dependent		Yes		No
6. Walking				
• Unassisted		Yes		No
• Use walking aids		Yes		No
• Wheelchair user		Yes		No
• Previous riding experience		Yes		No

Medication:				
a) Current medication				
Name	Dosage	Reason for usage	Positive effect	Side effect
b) Previous medication				
Name	Dosage	Reason for usage	Date and duration used	Reasons for stopping

Pregnancy					
Anaemia	Yes	No	Virus infection	Yes	No
High blood pressure	Yes	No	Other illnesses	Yes	No
Toxemia	Yes	No	Vomiting	Yes	No
Swollen ankles	Yes	No	Injuries	Yes	No
Kidney illness	Yes	No	Medication used	Yes	No
Heart problems	Yes	No	Placenta dysfunction	Yes	No
Threatening miscarriage	Yes	No	Black outs	Yes	No
Early contractions	Yes	No	Emotional problems	Yes	No
Measles	Yes	No	other	Yes	No

Birth			
	Yes	No	Details
Premature			
Fullterm			
Post mature			
Normal birth			
Cesarean			
Induction			
Instrument			
Other			
Duration of birth			
Medication received during birth			
Did the child have any of the following:			
Breathing problems			
Umbilical cord around neck			
Incorrect position			
Baby cry immediately			
Was baby's colour normal?			
Was baby in incubator?			
Jaundice			
Weight at birth			
Apgar score			

Developmental History (If any of the following do not apply, don't answer it):				
Developmental milestones	Yes	No	Age	Describe
Sit				
Crawl: How long				
Method of crawl				
Walking				
Running				
Jumping with 2 feet				
Ball: throw				
Catch				
Kick				
Climbing steps				
Riding bicycle				

Previous examinations/evaluations:

Has your child been evaluated by an Occupational Therapist before?

If so, by whom and when?

Who: _____

When: _____

Please include all reports by the following:

- Speech and Occupational therapist
- Paediatrician
- Psychologists
- School reports
- Neurologist

Please complete the following details of previous medical professionals:

Name:	
Profession:	
Contact Nr:	
Reason for Examination:	
Result of Examination:	
Recommendation:	

Name:	
Profession:	
Contact Nr:	
Reason for Examination:	
Result of Examination:	
Recommendation:	

Name:	
Profession:	
Contact Nr:	
Reason for Examination:	
Result of Examination:	
Recommendation:	

Family structure		
	Name	Describe relationship between your child and other persons:
Father		
Mother		
Brother/s		
Sister/s		
Grandpa		
Grandma		
Class teacher		
Domestic worker		
Friends		

Dominance			
Preference:	Left	Right	Details
Hands			
Feet			
Eyes			

Self-Care				
Development Goals	Yes	No	Age	Details
Drink from Bottle				
Drink from cup				
Drink from Glass				
Unbutton Clothes				
Use a zip up and down				
Put on socks				
Tie and loosen shoelaces				
Tie a bow				
Put on/remove jersey				
Toilet Routine				
Mess/clumsy when eating.				

Hand Function				
Is your child able to:				
Development Goals	Yes	No	Age	Details
Handling of Objects				
Grip a pencil				
Write				
Scribble				
Colour				
Draw				
Cut with scissors				

Balance System				
Development Goals	Yes	No	Age	Details
Is/was your child afraid of being thrown in the air?				
Does he/she enjoy riding on Dads shoulders?				
Is he/she afraid of escalators, lifts or climbing stairs?				
Does the child enjoy spinning/rolling movements?				
Does the child avoid balancing exercises?				
Did the child have trouble learning to ride a bike?				
Does the child easily get carsick or queasy?				
Does the child enjoy playing on jungle gyms?				

Reaction to physical contact				
Development Goals	Yes	No	Age	Details
Does the child enjoy hugs?				
Does the child show resistance to physical contact with:				
a. Familiar People				
b. Strangers				
Does the child enjoy touching people/animals?				
Is he/she inclined to fight or push other children away?				
Does the child avoid walking barefoot?				
Does the child exhibit resistance to cutting/washing hair?				
Does the child avoid certain food textures?				
Is the child often not aware of physical touch?				
Is the child unaware of painful events like injections?				
Does the child wear too much clothes as if unaware of temperatures?				
Is the child sensitive to bath/food temperature?				
Does the child avoid certain textures ie. Rough jerseys/nametags?				

Muscle Control				
Development Goals	Yes	No	Age	Details
Does the child tire easily?				
Does the child appear clumsy				
Does he/she break toys easily?				
Does the child tend to lay on his/her arms or support their head with his/her hand, while working?				
When the child is concentrating, does he/she have their tongue in their cheeks?				

Visual functioning				
Developmental goals	Yes	No	Age	Details
Does the child have any visual defects?				
Does the child wear glasses?				
Is the child able to differentiate between colours?				
Are the child's eyes sensitive to light?				
Does the child have a tendency to blink?				
Are the child's eyes usually red?				
Does the child tend to bend his/her head close to the table when working?				
Is the child inclined to close his/her eyes when asked to look at something?				
Does the child sometimes express or pronounce words or sentences wrongly?				
Eyes tested			By whom:	
			Where:	
			Contact nr:	
			Report:	

Language and communication skills

What is your concern about your child's present language and communication skills (if you are aware of any):

What is being done/has been done, to improve the present situation?

Name of speech therapist:

Is your child able to complete simple tasks on command?

Is your child able to remember and pass on messages?

Is your child able to sing songs and nursery rhymes?

Are there any sounds that your child cannot say or that he/she pronounces wrong?

Is your child able to tell a story or an event that happened in a logical manner?

Cognitive development:

When did you first recognize that your child had a problem?

Was your child school ready when he/she went to school?

Do you help the child with homework?

Describe how your child memorizes things; can he/she remember things well?

How is your child's concentration?

Are you content with your child's routine, how he/she takes on tasks and the child's understanding of his/her work?

Affective development (mark with a cross the behaviour that occurs):			
Irritated	Unknowingly destructive(destroying)	Aggressive with others	Is easily excited
Talks a lot	Stubborn and will not co-operate	Cannot sit still	Attention is easily distracted
Fidgets a lot	Restless, looks and listens partly to story	Appears impulsive.	Considers the task first before taking action.
Describe how your child is emotionally:			
How does he/she handle disappointment?			
What does he/she do when punished?			
Is he/she self-supporting and independent enough to your mind?			

Normality development:
How does the child accept authority from the following persons:
a) Father:
b) Mother:
c) Teacher:
How does your child accept responsibility?
Does the child have perseverance?
Who takes care of the child after school?
What opinion does the child have of his/her school?
Can he/she delay the pleasure and rather work on something important?

Sleep pattern (does your child have any of the following problems):				
Developmental goals	Yes	No	Age	Details
Staying up late				
Waking up during the night				
Waking up very early				
Struggle to go to sleep				
Restless during sleep				

School progress:
Pre- school:
Did your child attend a nursery school? _____
How was the integration with the nursery school/playgroup? _____

Report from nursery school/playgroup? _____
Socialising _____
Concentration _____
School:
Describe according to your impression, how the child is progressing at school: _____

Does your child have any friends? _____
How do they get on with one another? _____

What does your child complain about the most when he/she returns from school? _____

Anything else that will help us to understand your child better?

Does your child:	Yes	No		Yes	No
Fantasise a lot			Sometimes absent minded and not aware of what is going on around him/her		
Daydream easily			Enjoys reading/listening to stories		
Likes order and routine			Enjoys reading/listening to real life stories		
Love music			Likes to do things in a manner that other people like		
To solve problems in a logical manner			Likes to be affectionate towards others		
Choose to only tell a story			Choose to rather act out stories		
Likes to adhere to/complete commands/tasks given			Likes to do things on their own/in their own way		