

THERAPEUTIC RIDING AT BREEZY HILL, INC

BREEZY HILL FARM

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Client Name _____

Date of Birth _____

Parent/Guardian _____

Street _____

Town _____

Telephone _____

Cell Phone _____

Email _____

Fax _____

EMERGENCY CONTACT _____ **PHONE NUMBER** _____

List any Adverse/Allergic Reactions (Medications, Environmental/Food)

Primary Diagnosis: _____

List any Medical Problems, Diagnoses, Procedures:

List Medications you are currently taking at initial visit. Initial and date any changes.

(1) _____	(6) _____
(2) _____	(7) _____
(3) _____	(8) _____
(4) _____	(9) _____
(5) _____	(10) _____

Form completed by _____ Relationship to patient _____ Date _____

Dates Reviewed (Sign and Date):

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