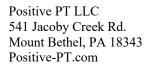




Participant Application & Health History

GENERAL INFORMATION:

Participant name			DOB	Age			
Address							
City							
Gender: M / F							
Height Weight*							
* 200-LB WEIGHT LIMIT DEPENDANT UPO	N AMBULATORY STATUS, RO	OM, AND THE	RAPIST DISCRETION	I			
Parent/Legal Guardian		Relationship					
Address (if different from above))						
Email Address							
		Phone-other (specify)					
How did you hear about us?							
HEALTH HISTORY (attach add	·						
Diagnosis/Disability Other therapies currently receive							
Current medications							
Psycho-social function (interests,							
Prior experience with therapeutic	c riding or hippothera	oy? YES /]	NO				
If so, when and where?							





Does the student	YES	NO	Comments			
Have a history of seizures?						
Follow simple directions?						
Have speech or language difficulties?						
Have communication difficulties?						
Have a fear of animals/horses?						
Walk independently?						
Have limited range of motion?						
Have decreased strength/endurance?						
Have poor balance (sitting/standing)?						
Have problems with gross motor skills?						
Have problems with fine motor skills?						
Have altered sensation? (specify)						
Have heart/circulation problems?						
Have digestion/elimination problems?						
Have bone/joint problems?						
Have allergies or breathing problems?						
Have emotional/behavioral problems?						
What would you like to accomplish?						
ADDITIONAL COMMENTS: Please provide any additional information that you feel would be helpful.						
Participant signature			Date			
Parent/Guardian signature			Date	-		