LiftMeUp!

PARTICIPANT'S APPLICATION AND HEALTH HISTORY

CONTACT INFORMATION

Participant Name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (M) _____ (Alt) _____

Employer/School Address: _____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian Name: _____

Caregiver Name (if applicable): _____

Address (if different than above): _____

City: _____ State: _____ Zip: _____

Phones (if different than above): (M) _____ (Alt.) _____

Are you available to participate on weekday mornings? Yes _____ No _____

If yes, which momings? _____

How did you hear about our program?

Referral Source: _____

GENERAL RIDER INFORMATION

Participant Date of Birth (MM/DD/YYYY): _____

Height: _____ **Weight:** _____ **Gender: M | F**

RIDER HEALTH HISTORY

Diagnosis: _____ Date of onset: _____

	Y	N	COMMENTS
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

Medications (please include prescription, over-the-counter: name, dose & frequency):

_____
_____
_____
_____

Please describe your abilities or limited abilities in the following areas:

(include assistance required or equipment needed)

- Physical Function: (i.e., mobility skills such as transfers, walking, wheelchair use, driving, bus riding, etc.)

  _____
  _____
  _____

- Psycho/social Function: (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fear/concerns, etc.)

  _____
  _____
  _____

- Goals: (i.e., Why are you applying for participation? What would you like to accomplish?)

  _____
  _____
  _____

- Other Information:

  _____
  _____
  _____

Signature: _____ Date: _____