Paws for Reflection Ranch

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RIDER INFORMATION FORM

Rider Name: _____ Date of Birth: ____/____/____ Age: _____ Gender ☐ M ☐ F

Parent/Legal Guardian *(if Rider is under 18)*:_____

Address: _____ City: _____

County: _____ Zip: _____ Phone: _____ Alt Phone: _____

Email: _____ Employer: _____

RIDER HEALTH HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? ☐ YES ☐ NO

Rider/Parent/Legal Guardian Signature: _____

Rider Diagnosis:_____Rider Weight: _____

Current medications being taken:

1)_____ Dosage/Freq _____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

Please indicate current or past special needs in the following areas:

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

Describe your Physical Function abilities/difficulties *(including assistance required or equipment needed)*:_____

_____

_____

_____

_____

GOALS *(i.e. why are you applying for participation? What would you like to accomplish?)*

_____

_____

_____

_____

Signature: _____ Date: _____

Client, Parent or Legal Guardian

THANK YOU