Participant's Application & Health History

GENERAL INFORMATION

Participant: _____
DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
Address: _____
Phone: _____ Email: _____ Alternative Number_____
Employer/ School: _____
Address: _____ Phone: _____
Parent/ Legal Guardian: _____
Caregivers: _____
Address (if different): _____ Phone: _____
How did you hear about our program: _____
Referral Source: _____

HEALTH INFORMATION

Diagnosis: _____ Date of Onset: _____

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

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

MEDICATIONS (include prescription and over-the-counter, name, dose, and frequency)_____

_____

_____

_____

_____

Describe your abilities/difficulties in the following areas (including assistance required or equipment needed)

PHYSICAL FUNCTION (e.g. mobility skills such as transfers, walking, wheelchair use, driving/ bus riding)

_____

_____

_____

_____

_____

_____

PSYCHOSOCIAL FUNCTION (e.g. work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

_____

_____

_____

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

_____

_____

_____

Signature: _____ Date: _____

Photo Release

I ☐ Do

☐ Don't

Consent to and authorize the use and reproduction by Hero Horse, LLC of any and all photographs and any other audio/visual material taken of me for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Signature: _____ Date:_____

Client, Parent or Legal Guardian