PARTICIPANT'S APPLICATION AND HEALTH HISTORY

(To be completed by the participant's parent/legal guardian.)

GENERAL INFORMATION

Participant Name: _____ Date of Birth: _____

Current Height: _____ Current Weight:_____ Gender: ☐ M ☐ F Race *(for grant purposes only)*: _____

School (if applicable): _____ Referral Source: _____

What other therapies has your child done? _____

How did you hear about the program? _____

HEALTH HISTORY

Primary Diagnosis: _____ Date of Onset: _____

Secondary Diagnosis: _____ Date of Onset: _____

Seizures:☐ Yes ☐ No Type:_____ Date of Last Seizure:_____

Notes: _____

Scoliosis: ☐ Yes ☐ No Type/Severity_____ Notes:

_____

Please indicate if your child is within normal limits (WNL) or comment if they have a special need or concern in the chart below

	WNL	Comments
Vision	☐	
Hearing	☐	
Sensation	☐	
Communication	☐	
Heart	☐	
Breathing	☐	
Digestion	☐	
Elimination	☐	
Circulation	☐	
Emotional/Mental Health	☐	
Behavioral	☐	
Social Skills	☐	
Pain	☐	
Bone/Joint	☐	
Muscular	☐	
Mobility	☐	
Thinking/Cognition	☐	
Allergies	☐	

**** Form continues on back ****

MEDICAL/HEALTH QUESTIONS

Sensitivities to Heat/Cold/Sun: _____

Medications (include prescription, over –the-counter; name, dose and frequency) _____

_____

_____

_____

_____

Other Precautions: (i.e. shunt, implant, port, etc.): _____

Additional Notes/Comments: _____

_____

_____

PARTICIPANT INFORMATION QUESTIONS

Has your child been on/around a horse before? ☐ Yes ☐ No

If yes, how was the experience: _____

How does your child communicate? _____

When your child is frustrated, how do they react? _____

Interests/Motivations: _____

Dislikes/Fears: _____

Social Skills: _____

Family Structure (siblings, pets, custody, hobbies):_____

Goals (i.e. Why are you applying for participation? What would you like for your child to accomplish?)

_____

_____

_____

_____

ADDITIONAL COMMENTS/CONCERNS

_____

_____

_____

Signature: _____ **Date: _____**

Parent/Legal Guardian