Horses In Service Natural Therapeutic Riding Center

Participant Health History

General Information:

Name:_____

DOB _____ Age _____ Height _____ Weight _____ Gender☐M ☐ F

Address: _____

Phone:_____ Alternative: _____

Email address: _____

School/Employer: _____

Parent/Legal Guardian's Name: _____

Address (if different): _____

Phone: _____ Alternative: _____

Email address: _____

Health History:

Primary diagnosis:_____ Date of onset: _____

Secondary diagnosis:_____ Date of onset: _____

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

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

Medications: (*including prescription, over the counter, name, dose and frequency)*:

_____

_____

_____

_____

Describe your (or the participant's) abilities/difficulties in the following areas (include assistance required or equipment needed):

Physical Function: (Mobility skills such as transfers, walking, wheelchair use, driving/bus riding):

_____

_____

_____

_____

Psycho/Social Function: (Work/School including family structure, relationships, support systems, companion animals, grade completed, leisure interests, fears/concerns, etc.)

_____

_____

_____

_____

Goals: (What would you like to accomplish?)

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date**: _____
(Participant) (Parent or Legal Guardian if under age 18)