Lichen Oaks Adaptive Riding Center

Participant's Application & Health History

GENERAL INFORMATION

Participant: ____

Date of birth : ______________________ Age: ________ Height: ________ Weight: __________

Gender (please circle): M F

Address: ____

Phone: _____________________________ E-mail: _________________________________

Alternative phone number(s): ____

Employer/School: ____

Address: ____

Phone: _____________________________________

Parent/Legal Guardian: ____

Caregivers: ____

Address (if different from above): ____

Phone: _____________________________________

Referral Source: ____

Phone: ______________________________________

How did you hear about the program? ____

____

Additional comments/concerns? ____

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Lichen Oaks Adaptive Riding Center

Participant's Application & Health History (continued)

HEALTH HISTORY

Diagnosis: ____

Secondary diagnosis: ____

Date(s) of Onset: ____

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			

MEDICATIONS (include the name, dose, and frequency taken of both prescription and over-the-counter medications):

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____

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____

ALLERGIES ____

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____

Participant's Application & Health History (continued)

Describe your abilities/difficulties 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):

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____

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

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____
____
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____
____

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

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____
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____
____

Signature: ____

Date: ____