



## Participant's Application & Health History

### GENERAL INFORMATION

Participant Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M      F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

School: \_\_\_\_\_ T-Shirt Size: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Caregivers: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

Lesson type: \_\_\_\_\_ Group \_\_\_\_\_ Private      Payment: \_\_\_\_\_ One time payment \_\_\_\_\_ Monthly

### HEALTH HISTORY

Diagnosis: \_\_\_\_\_

Date 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			
Allergies			

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

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

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

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

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

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHOTO RELEASE

I  DO

DO NOT

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client, Parent or Legal Guardian