



Horses with Hearts, Inc.
Therapeutic Riding
 PO Box 2186, Martinsburg, WV, 25402

Participant's Application and Health History

GENERAL INFORMATION:

Participant: _____

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

Address: _____

Phone: _____ Cell #: _____ Alternative #: _____

Email Address: _____

Emergency Contact Information: Name: _____

Relationship: _____

Phone #: _____ Cell #: _____

Employer / School: _____

Address: _____

Phone: _____

Parent/Legal Guardian/Caregivers: _____

Employer: _____ Occupation: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

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, over the counter; name, dose and frequency) _____

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)

PSYCHO/SOCIAL FUNCTION (i.e., 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
 _____ DO NOT

Consent to and authorize the use and reproduction by Horses with Hearts, Inc. of any and all photographs and other audio/visual materials taken of me and/or my family members for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____