EAST CENTRAL INDIANA

Therapeutic Riding, Inc.

Contact: Elise Matthews
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(765) 730-2747

Participant's Application and Health History

GENERAL INFORMATION

Participant:____

DOB:__________________ Age:__________ Height:_____________ Weight:_______________ Male Female

Address:____

Phone:_____________________________ Alternative #:___________________________

Employer/School:____

Address:____

Phone:____

Parent/Legal Guardian:____

Address (if different from above):____

Phone:____

Referral Source:____

Contact Numbers:____

How did you hear about the program?____

PHOTO RELEASE

I (DO / DO NOT) consent to and authorize the use and reproduction by East Central Indiana Therapeutic Riding Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:____ Date:_____________________

Client, Parent or Legal Guardian
Signed in the presence of center staff

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	*N*	*Comments:*
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

*What medications are you currently taking, including over-the-counter medications?*________________________________
____
____

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

FUNCTION: *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*
____
____
____
____

SOCIAL: *(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?)*
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