



Participant's Application and Health History

GENERAL INFORMATION of

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

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

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

Phone: \_\_\_\_\_ ,E-mail: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

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

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

Parent/Legal Guardian/Caregivers:

\_\_\_\_\_

Address (if different from above):

\_\_\_\_\_

Phone: \_\_\_\_\_ Referral Source or how did you hear about HorsePower:

\_\_\_\_\_

HEALTH HISTORY Diagnosis, Date of Onset: \_\_\_\_\_

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

Health History			
	Yes	NO	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)

---



---



---



---

\_\_\_\_\_ PSYCHOLO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, ect.)

---



---



---



---

\_\_\_\_\_ 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 \_\_\_\_\_ (center) of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or any other use for the benefit of the program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Client, Parent, or Legal Guardian

Participant's Consent for Release of Information I hereby authorize: HorsePower Inc to release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_ (Participant's name) The information is to be released to: HorsePower Inc for the purpose of developing an equine activity program for the above named participant. The information to be released is indicated below:  Medical History  Physical Therapy evaluation, assessment and program plan  Occupational Therapy evaluation, assessment and program plan  Speech Therapy evaluation, assessment and program plan  Mental Health diagnosis and treatment plan  Individual Habilitation Plan (I.H.P.)  Classroom Individual Education Plan (I.E.P.)  Psychosocial evaluation, assessment and program plan  Cognitive-Behavioral Management Plan  Other: \_\_\_\_\_ This release is valid for one year and can be revoked, in writing, at my request.

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

Print Name: \_\_\_\_\_

Relation to Participant: \_\_\_\_\_

Please send materials to: HorsePower 5025 Garton Rd Castle Rock CO 80104