HEARTLAND THERAPEUTIC RIDING, INC.

P.O. Box 391 ▪ 19655 Antioch, Stilwell, Kansas 66085-0391
T 913-897-3939 ▪ F 913-730-5437 ▪ www.HeartlandTherapeuticRiding.org

Participant Application and Health History:

Participant Name: _____ Date: _____

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

Address: _____

Phone #: _____ Alt. #: _____ Email: _____

Parent/Legal Guardian: _____ Relationship to rider: _____

Address: _____

Phone #: _____ Alt. #: _____ Email: _____

Parent/Legal Guardian: _____ Relationship to rider: _____

Address: _____

Phone #: _____ Alt. #: _____ Email: _____

HEALTH HISTORY:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Please indicate the Rider's Special Needs in the following areas:

Visual: _____

Auditory: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Behavioral: _____

Musculoskeletal: _____

Cognition: _____

Allergies: _____

Emotional/Mental Health: _____

Any other areas of concern for Therapeutic Riding: _____

_____

To the best of my knowledge, the above information is accurate and reflects the medical history of the rider:

Participant/Guardian Signature Date

MEDICATIONS TAKEN (include Prescriptions AND Over the Counter, name, dose and frequency):

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

COGNITIVE FUNCTION:

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

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

To the best of my knowledge, the above information is accurate and reflects the medical history of the rider:

Participant/Guardian Signature Date