



# 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 2019:

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

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

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

Phone #: \_\_\_\_\_ Alt. #: \_\_\_\_\_ Email: \_\_\_\_\_

Parents/Legal Guardians: \_\_\_\_\_ Relationship to rider: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Alt. #: \_\_\_\_\_ Email: \_\_\_\_\_

Caregiver, if applicable: \_\_\_\_\_ Relationship to rider: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Alt. #: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Yes, send TEXT notifications to: \_\_\_\_\_ (cell phone #): \_\_\_\_\_

***\*\*This is how we will contact you in the event of a cancellation.\*\****

### HEALTH HISTORY:

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

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

#### ***Please note participant's impairments, injuries, needs or adaptive equipment 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 participant:***

Participant/Guardian Signature

Date

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

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

**COGNITIVE FUNCTION:** \_\_\_\_\_

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

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

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

Participant/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_