Participant's Application and Health History

To be completed by the participant or parent/legal guardian/caregiver

Participant: ____

DOB: ________________ Age: ____________ Height: ____________ Weight: ____________ Gender: M F

Address: ____

Phone: ________________ E-mail: ______________________________

Work Phone: ______________________________ Cell Phone: ______________________________

Alternate Phone (specify): ______________________________

Employer/School: ______________________________

Occupation: ______________________________

Address: ______________________________

Phone: ______________________________

Parent/Legal Guardian/Caregiver: ______________________________

Address (if different from above): ______________________________

Phone (if different from above): ______________________________

Grandparent(s) name and address: ______________________________

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?)