Charleston Area Therapeutic Riding, Inc.
P.O. Box 146 • Johns Island, SC 29457-0146 • (843) 559-6040 • Fax (843) 559-0176

P3

Health History Form

GENERALINFORMATION

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: _____

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:

	У	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			

MEDICATIONS *(include prescription, over-the-counter; name, dose and frequency)*

Please describe 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. What would you like the participant to accomplish?)*

Signature of Student or Parent or Legal Guardian

Date