# Participant's Application and Health History

**GENERAL INFORMATION**

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

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:*

| | 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?)

Signature: _____ Date: _____

Print [type] Name: