**Adaptive Riding Participant Application/Referral Form**

**Are you? \_\_\_\_\_\_\_ Participant\_\_\_\_\_\_\_\_ Referral Source**

Participant:

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

Address:

Phone: Email: Alternative #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School:

Address:

Phone:

Parent/Legal Guardian:

Caregivers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above):

Phone:

How did you hear about the program?

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source:

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

Phone:

**HEALTH HISTORY**

Medical Diagnosis: (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Diagnosis (if applicable): Axis I\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis II\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_

Tetanus Shot: Yes \_\_\_\_\_ No \_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\*For persons with Down Syndrome:)

Cervical x-ray for Atlantoaxial Instability: Positive \_\_\_\_\_ Negative\_\_\_\_ X-ray date\_\_\_\_\_\_\_\_\_\_\_

*Please indicate current or past special needs in the following areas*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Y | N | Comments |
| Aggression |  |  |  |
| Allergies |  |  |  |
| Autism |  |  |  |
| Behavioral |  |  |  |
| Bone/Joint (arthritis) |  |  |  |
| Cancer (type) |  |  |  |
| Circulation (heart disease, hypertension) |  |  |  |
| Communication |  |  |  |
| Depression/Anxiety |  |  |  |
| Dietary Problems |  |  |  |
| Dizziness |  |  |  |
| Elimination |  |  |  |
| Emotional/Mental Health |  |  |  |
| Epilepsy (Seizure Type) |  |  |  |
| Gastrointestinal Issues (peptic ulcers, etc.) |  |  |  |
| Head Injuries |  |  |  |
| Headaches |  |  |  |
| Hearing |  |  |  |
| Hyperactivity |  |  |  |
| Incoordination |  |  |  |
| Loss of Consciousness/Blackouts |  |  |  |
| Metabolic issues (diabetes, thyroid, etc.) |  |  |  |
| Muscular |  |  |  |
| Other illness (TB, AIDS, etc.) |  |  |  |
| Pain |  |  |  |
| Phobias |  |  |  |
| Respiratory/Asthma |  |  |  |
| Self-harm/Suicidal |  |  |  |
| Sensory Impairment |  |  |  |
| Sleep Disorders |  |  |  |
| Substance Abuse |  |  |  |
| Thinking/Cognition |  |  |  |
| Trauma/Abuse |  |  |  |
| Vision |  |  |  |
| Other |  |  |  |

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

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed): **PHYSICAL FUNCTION** (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding, level /frequency of exercise)

**PSYCHO/SOCIAL FUNCTION** (e.g.,. work/school including grade completed, learning disabilities, leisure interests, relationships-family structure, support systems, companion animals, social skills, fears/concerns, etc.)

**GOALS** (i.e. why are you applying for participation? What would you like to accomplish? Current treatment goals if applicable)

Participant Signature: Date:

**(This section for referral source if applicable:)**

Reason for Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or Recommended Treatment Goals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_