Riverwood Therapeutic Riding Center
6825 Rollingview Drive
Tobaccoville, NC 27050
(336) 922-6426

Participant's Application and Health History

(To be completed by participant, parent or legal guardian)

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Primary Phone: _____ Alternative #: _____ E-mail: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ **Date of Onset** _____

Seizure Type: _____ **Controlled: Y N** **Date of Last Seizure:** _____

Changes in frequency and seizure type: Y N **If yes, please describe:** _____

Implanted vagal stimulator: Y N **If yes, date of implant:** _____

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)* _____

_____

_____

_____

Signature: _____ Date: _____

Client, Parent or Legal Guardian