HEARTS Therapeutic equestrian center

Equine Services for Heroes
Participant Application & Health History

Name: _____ Date: _____

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

Address: _____

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

Emergency Contact: _____ Phone: _____

Parent/Legal Guardian/Caregiver: _____

How did you hear about our program: _____

Previous horse/riding experience: _____

Rider Health History

Primary Diagnosis: _____ Date of onset: _____

Secondary: _____ Date of onset: _____

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

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/joint			
Muscular			
Thinking/Cognition			
Allergies			