

## Equine Services for Heroes Participant Application & Health History

Name:		D at e:						
D0 B: Age:		Height:	v	Veight:	Gender:	M	F	
Address:								
E-mail:		Phone:	Alternative #:					
Emergency Contact:			Phone:					
Parent/Legal Guardian/	Caregiver:							
How did you hear about	t our program	1:						
Previous harse/riding ex	(perience:							
Rider Health Histo	ry							
Primary Diagnosis:					Date of onset:			
Secondary:				Date	Date of onset:			
Please indicate current o	or past specia	l needs in th	ne following area	5.				
	Υ	N	Comments					
Vision								
Hearing								
Sensation								
Communication								
Heart								
Breathing								
Digestion								
Emotional/Mental He	alth							
Behavioral								
Pain								
Bone/joint								
Muscular								
Thinking/Cognition								
Allergies								