



## *HOPE Therapeutic Riding Center*

P.O. Box 334, Langley, WA 98260 (360) 221-7656

Email: [hope@whidbey.com](mailto:hope@whidbey.com)

Website: [www.hope-whidbey.org](http://www.hope-whidbey.org)

### PARTICIPANT'S APPLICATION AND HEALTH HISTORY

#### GENERAL INFORMATION (PLEASE PRINT OR TYPE)

Participant: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Gender: Male Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Tel. #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer/School: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Parent/Legal Guardian (if a minor): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Tel. #: \_\_\_\_\_

E-mail: \_\_\_\_\_

How did you hear about HOPE? \_\_\_\_\_

Does your employer provide matching funds for donations to non-profit 501(c)(3) organizations? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

**HEALTH HISTORY (Use separate sheet if necessary)**

**Diagnosis:** \_\_\_\_\_

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

**Diagnosis:** \_\_\_\_\_

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

**Handedness:** Left Right

**Hearing Impaired:** Yes No **Hearing Aid:** Yes No **Which ear(s):** Left Right Both

**Uses Sign Language:** Yes No **Lip reads:** Yes No **Needs interpreter:** Yes No

**Severely Visually Impaired:** Yes No If yes, explain \_\_\_\_\_

\_\_\_\_\_

The following information is requested in order for HOPE Therapeutic Riding Center to be better aware of the student's various medical providers, community resources used and treatments being received. HOPE may need to contact one or more of the providers for the sole purpose of clarifying any information provided to better assist the HOPE Head Instructor's assessment of the student's abilities and limitations and develop an appropriate plan for the student's lessons. Copies of summary results, therapy regimens, and Individual Education Plans (IEP) are most helpful. HOPE has Release of Information consent forms available for you to give to your providers.

**Primary Health Care Provider:** \_\_\_\_\_ **MD PA NP Other:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Physical Therapist:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Occupational Therapist:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Speech Therapist:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Mental Health Provider:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Special Education Teacher:** \_\_\_\_\_

**Name of School:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Other Service Provider:** \_\_\_\_\_

**Name of Practice/Hospital:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**(Use separate sheet if necessary)**

Please indicate current or past special needs in the following areas: *(Use separate sheet if necessary)*

	YES	NO	COMMENTS
<b>Allergies</b>			
<b>Behavioral</b>			
<b>Bone/Joint</b>			
<b>Breathing</b>			
<b>Circulation/Heart</b>			
<b>Cognitive/Thinking</b>			
<b>Communication/Speech</b>			
<b>Digestion/Elimination</b>			
<b>Emotional/Mental Health</b>			
<b>Hearing</b>			
<b>Motor skills (Fine/Gross)</b>			
<b>Muscular</b>			
<b>Neurological/Seizures</b>			
<b>Pain</b>			
<b>Prosthetics/Braces</b>			
<b>Sensation</b>			
<b>Vision</b>			
<b>Other:</b>			

**MEDICATIONS** (prescription, OTC; name, dose, frequency and purpose)

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**Describe the student's abilities/difficulties in the following areas (include assistance required or equipment needed): (Use separate sheet if necessary)**

**PHYSICAL FUNCTION** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding, use of hands)

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**PSYCHO/SOCIAL FUNCTION** (i.e. Work/School including grade completed, leisure interests, relationships,-family structure, support system, companion animals, forms/concerns, etc.)

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**GOALS** (i.e. Why are you applying? What would you like to accomplish? Example, improve strength/balance, verbal skills, social skills, control emotions, competition, recreation, etc.)

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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Adult Student/Parent/Legal Guardian)