



Participant Application and Health History

GENERAL INFORMATION:

Participant

Date of Birth _____ Age _____ Height _____ Weight _____ Gender M F

Address _____

City _____ State _____ Zip _____ Phone _____

E-mail _____ Alternate Phone _____

Employer/School _____

Address _____

City _____ State _____ Zip _____ Phone _____

Parent/Legal Guardian _____

Address (if different from above) _____

City _____ State _____ Zip _____ Phone _____

Referral Source _____ Phone _____

How did you hear about this program? _____

Physician _____

Address _____ Phone _____

Other Healthcare Providers

(Physical or Occupational Therapist; Speech-Language Pathologist, Mental Health Provider)

Provider Name _____ PT OT SLP MHP Other _____

Address _____ Phone _____

Provider Name _____ PT OT SLP MHP Other _____

Address _____ Phone _____

HEALTH HISTORY:

Diagnosis _____ Date of Onset _____

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)

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

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

PSYCHO/SOCIAL FUNCTION (i.e. Work/school including grade completed, leisure interests, relationships, family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

Participant Signature

Date

(not required if participant is a minor has guardian)

Signature

Date

Parent or Legal Guardian

Table with 2 rows: Date, Initials and 6 empty columns.