JAF's THERAPY IN MOTION
5730 Lafayette Rd.
Medina, OH 44256
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PARTICIPANT'S APPLICATION AND HEALTH HISTORY

GENERAL INFORMATION

Participant _____ DOB _____

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

Address _____ City _____ Zip _____

Home Phone _____ Alternative # _____ Email _____

Name of School _____City _____

Parent's Name/Legal Guardian _____

Address *(if different than above)* _____ City _____

Home Phone _____ Cell # _____ Email _____

Caregiver's _____ Phone _____
(who may be driving participant to and from session's, i.e. nurse, sitter, etc.)

Referral Source _____

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			
Additional Information			

Name _____

MEDICATIONS (Include prescription, over the counter; name, dose and frequency)

_____
_____
_____
_____
_____
_____

Please describe abilities or 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 (What would you like to accomplish?)

_____
_____
_____
_____
_____
_____
_____

Signature: _____ **Date:** _____
(Client, Parent or Legal Guardian)

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International