harmony family center

so children may live their best lives

Participant Application & Health History

To be completed by participant or parent/legal guardian

General Information

Participant Name: _____

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

Address: _____

(Street) (City) (State) (Zip)

Cell Phone: _____ Alternate Phone: _____

E-Mail: _____

Preferred method(s) of contact: Phone Call _____ Text Message _____ E-mail _____

School or Employer: _____

Address: _____

(Street) (City) (State) (Zip)

Please indicate the program(s) that interest you:

EAP: _____ Therapeutic Riding: _____ (30 min) _____ (1 hour)

How did you hear about Harmony's Animal-Assisted Therapy program? _____

Name of Parent/Legal Guardian: _____

Address (if different from above): _____

(Street) (City) (State) (Zip)

Cell Phone (if different from above): _____

Name of Caregiver (if different from above): _____ Phone: _____

Health History

Diagnosis: _____ Date of Onset: _____

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

	Yes	No	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, dosage, and frequency)*

Please describe abilities or difficulties in the following areas (include assistance or special equipment required):

PHYSICAL FUNCTION *(e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

PSYCHOSOCIAL FUNCTION *(e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

GOALS: What would you like to accomplish through participation in this program?

Signature: _____ Date: _____

Client, Parent, or Legal Guardian