



Participant Registration & Health History

GENERAL INFORMATION:

Name: _____ Date: _____

Address: _____

Employer/School: _____

Work Address: _____

Date of Birth: _____ Phone: (H) _____ (W) _____

E-Mail Address: _____

Parent/Legal Guardian Name and Address: _____

How did you hear about the program? _____

Recent medical tests: Last Tetanus Shot: _____ Tuberculosis Test + --Date: _____

(Consult your physician/local health department if you are not up to date with these shots/tests)

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			

(over)

MEDICATIONS (include prescriptions, 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?)

PHOTO RELEASE

I do or do not consent to and authorize the use and reproduction by Windsong Equitherapy of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian Please sign in the presence of center staff