
*Therapeutic Riding*
*Enrollment Paperwork*

## GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Address:_____

Phone: _____ Email: _____

What is the best way to contact you? Circle one: Text Email Phone Other

Parent/Legal Guardian (i.e. parent, self):_____

Address (if different from above)_____

_____

Phone: _____

How did you find us? _____

**GOALS**: What would you like to accomplish through our programs?

_____

_____

_____

## HEALTH HISTORY

Diagnosis: _____Date of Onset: _____

Current allergies/medications: (please include over the counter and prescription, dose and frequency so that we can best respond in case of an emergency)_____

_____

_____

Does participant need any equipment or assistance for physical function?

_____

_____

Does participant need any equipment or assistance for psychosocial function?

_____

_____

*253 Sandy Hill Drive ◆Marshfield, MA 02050◆erinfbf@gmail.com◆ (617)650-5524*


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*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 | | | |

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