Therapeutic Equestrian Program
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?

_____

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			