

*Riverwood Therapeutic Riding Center
6825 Rollingview Drive
Tobaccoville, NC 27050
(336) 922-6426*

Participant's Application and Health History
(To be completed by participant, parent or legal guardian)

GENERAL INFORMATION

Participant: _____
 DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F
 Address: _____
 Phone: _____ E-mail: _____ Alternative #: _____
 Employer/School: _____
 Address: _____
 Phone: _____
 Parent/Legal Guardian: _____
 Address (if different from above): _____
 Phone: _____
 How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset _____
 Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____
 Changes in frequency and seizure type: Y N If yes, please describe: _____
 Implanted vagal stimulator: Y N If yes, date of implant: _____

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

| | <i>Y</i> | <i>N</i> | <i>Comments</i> |
|--------------------------------|----------|----------|-----------------|
| <i>Vision</i> | | | |
| <i>Hearing</i> | | | |
| <i>Sensation</i> | | | |
| <i>Communication</i> | | | |
| <i>Heart</i> | | | |
| <i>Breathing</i> | | | |
| <i>Digestion</i> | | | |
| <i>Elimination</i> | | | |
| <i>Circulation</i> | | | |
| <i>Emotional/Mental Health</i> | | | |
| <i>Behavioral</i> | | | |
| <i>Pain</i> | | | |
| <i>Bone/Joint</i> | | | |
| <i>Muscular</i> | | | |
| <i>Thinking/Cognition</i> | | | |
| <i>Allergies</i> | | | |

MEDICATIONS *(include prescription, over-the-counter, name, dose and frequency)* _____

Signature: _____
 Client, Parent or Legal Guardian

Date: _____