Participants Application And Health History

GENERAL INFORMATION

Participant: _____

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

Address: _____

Phone: _____ Email: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

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			
Behavior			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

Medications (include over the counter; name dose and frequency)

Physical Function

Psychological Function

Goals

Signature:_____ Date: _____

Photo Release

I DO

I DO NOT

Consent to and authorize the use and reproduction by _____ 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:_____