THE DALA CENTER

THERAPEUTIC RIDING & EQUINE ASSISTED LEARNING

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**Participant Application and Health History**

Participant Name:_____

DOB:_____Age:_____Height_____Weight_____Gender_____

Address: _____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Email:_____

Employer/School:_____

Parent/Legal Guardian:_____

Address (if different from above):_____

Phone(s):_____

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 | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |

**Medications** (include prescription, over-the-counter name, dose, frequency):_____

_____

_____

_____

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed)

**Physical Function** (e.g. mobility skills such as transfers, walking, wheelchair use, driving, bus riding):

_____

_____

_____

**Psychosocial Function** (e.g.work/school including grade completed, leisure interests, relationships/family structure, support systems, companion animals, fears/concerns):

_____

_____

_____

**Goals** (Why are you applying? What do you wish to accomplish?):_____

_____

_____

Signature:_____Date:_____