simple changes
THERAPEUTIC RIDING CENTER

Participant Health History

Mail To:
Simple Changes
PO Box 991
Lorton, VA 22199

Participant Name_____

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			

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

- **Medications** (include prescription, and over-the- counter) Attach additional sheet if needed.

  _____

- **Goals** (Why are you applying for participation? What would you or your child like to accomplish?)

  _____

  _____

- **Psycho/Social Function** (ie: Work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns., etc.)

  _____

  _____

- **Physical Function** (ie: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

  _____

  _____

Please make sure that the staff at Simple Changes is kept current on new progress/issues that arise with your participant's health. If your child has seizures please fill out the seizure information form completely.

Signature: _____ **Date**: _____
Participant (if over 18), Parent or Legal Guardian

Subsequent Year Initials: _____ Date: _____ Subsequent Year Initials: _____ Date: _____
Participant (if over 18), Parent or Legal Guardian Participant (if over 18), Parent or Legal Guardian