



# SEAPONY FARM

## Participant's Application and Health History

### General Information:

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Alternative #: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Alternative #: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### Health History:

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

*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			



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

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

**Physical Function:** (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

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

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**Goals:** (i.e. Why are you applying for participation? What would you like to accomplish?)

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Name: \_\_\_\_\_ *(print legibly)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

