Rising Hope Farms

Participant's Application and Health History

General Information

Participant:_____

DOB:_____ Age_____ Height:_____Weight:_____Gender: M F

Address_____

Cell Phone:_____ House Phone #_____Work Phone_____

E-mail_____

Employer/School _____

Address _____

Phone: _____

Parent/Legal Guardian/Caregivers_____

(if different from above)

Address_____

Phone: _____Work Phone:_____Cell Phone_____

Health History

Diagnosis _____Date of Onset: _____

Please indicate current special needs in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			

Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/cognition			
Allergies			

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

_____

_____

_____

_____

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

PHYSICAL FUNCTION *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION *(work/school including grade, leisure interests, relationships, family structure, companion animals, rears/concerns/ etc*

_____

_____

_____

_____

_____

GOALS *(what would you like to accomplish through this program)*

_____

_____

_____

_____

_____

Signature:_____ **Date**_____