

TROT

Therapeutic Riding of Temecula



951 326-6464

Touch a Miracle

www.TROTwithhorses.com

Rider Application and General Health History

GENERAL INFORMATION

Date: _____

Rider's Last Name: _____ First Name: _____

Parent/Guardian Name: _____

Address: _____ City: _____

Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address _____

DOB: _____ Age: _____ Height: _____

Weight: _____ Gender: M F

School: _____ Phone: _____

Teacher: _____ Phone: _____

How did you come to know about our program?

What are your goals:

HEALTH HISTORY

Diagnosis: _____ Date of Onset: _____

Please indicate current needs if applicable.

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/Mental			

Health			
Behavioral			
Pain			
Muscular			
Thinking/Cognition			
Bone/Joint			
Allergies			

MEDICATIONS

Name	Prescription	Over the Counter	Dose	Frequency

PHYSICAL FUNCTION

Describe abilities/difficulties in the following areas (include assistance required or equipment needed) For example: Mobility skills such as transfers, walking, wheelchair use, driving/bus riding.

PYSCHO/SOCIAL FUNCTION

What grade completed/workforce, leisure interests, family structure, relationships, support systems, pets, fears, concerns, etc.

Comments:
