



Stable Hands P.O. Box 1852 Yreka CA 96097 (530) 842-3082 www.stablehands.org

Participant’s Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ E-mail: _____ Alternative phone: _____

HEALTH HISTORY

Primary Diagnosis: _____ Secondary Diagnosis (_____

Date of onset: _____

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

	Y	N	Comments
Auditory			
Visual			
Sensations			
Speech/Communications			
Heart/Cardiac			
Breathing			
Digestion			
Elimination			
Muscular			
Circulation			
Bone & Joint			
Allergies			
Thinking/Cognition			
Emotional/Mental Health			
Behavioral			
Pain			
Other			

Military Service History (Branch of service; when and where did you serve; what was your military job specialty)

Please describe abilities/difficulties in the following areas (include assistance required or equipment needed).

Function (Mobility skills such as transfers, walking, wheelchair use, driving a car)

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

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

Do you have experience with horses? If yes, please describe.

Signature: _____
Veteran, or Legal Guardian

Date: _____