



The Carriage Barn Equestrian Center Therapeutic Riding Program

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A 501(c)3 Not-For-Profit Organization

Participant's Application and Health History

GENERAL INFORMATION

Client Name: _____ DOB: _____ Age: _____

Sex: _____ Height: _____ Weight: _____

Address: _____ Day Phone: _____

_____ Eve. Phone: _____

Email: _____

Physician: _____ Phone: _____

Employer / School: _____

Address: _____ Phone: _____

Parent / Legal Guardian: _____

Address: _____ Phone: _____

Referral Source: _____

Contact Numbers: _____

How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognition			
Allergies			

(over)

What medications are you currently taking, including over-the-counter medications?

Describe your abilities / difficulties in the following areas (including assistance / equipment required)
FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving / bus riding)

SOCIAL (i.e. Work / School including grade completed, leisure interests, relationships / family structure, support systems, companion animals, fears / concerns, etc.)

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