THE RIGHT STEP, INC.

THE HEALING POWER OF HORSES

A PATH Intl. Premier Therapeutic Riding Program

Client Health History

(Must be completed by parent/guardian if under 18 or unable to sign legal documents)

Name: _____

Disability/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			
Seizures			

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

_____

_____

_____

_____

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

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

_____

_____

_____

_____

PSYCHO/SOCIAL FUNCTION *(e.g., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)*

_____

_____

_____

_____

GOALS *(i.e. why do you want to participate in equine assisted activities? What would you like to accomplish?)*

_____

_____

_____

_____

_____ _____

Signature Date