



# Therapeutic Riding Center

181 Franklin Farm Lane  
Chambersburg, PA 17201



Barn: 263-0443

Office: 263-9226

## Participant's Application and Health History

### GENERAL INFORMATION

Date of Application: \_\_\_\_\_

Participant: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Parent/Legal Guardian: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Contact Number(s): \_\_\_\_\_

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			



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

Do you suffer from seizures? If so, please describe. We require that participants be seizure free for at least 6 months.

Have you had any recent fractures or surgeries? If so, please describe and include dates.

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

**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?)

**PHOTO RELEASE**

I DO

I DO NOT

consent to and authorize the use and reproduction by Franklin County Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Client, Parent or Legal Guardian  
*Signed in the presence of center staff*

**Please return to: Robert Kessler  
191 Franklin Farm Lane  
Chambersburg, PA 17201**