Participant’s Application & Health History

**GENERAL INFORMATION**

Participant:

DOB:

Age:

Height: Weight:

Gender:

M

F

Address:

Phone: Email: Alternative #:

Employer/School:

Address:

Phone:

Parent/Legal Guardian:

Caregivers:

Address (if different from above):

Phone:

Referral Source:

Phone:

How did you hear about the program?

**HEALTH HISTORY**

Diagnosis:

Date of Onset:

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

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2018

122

Y

N

Comments

Vision

Hearing

Sensation

Communication

Heart

Breathing

Digestion

Elimination

Circulation

Emotional/Mental Health

Behavioral

Pain

Bone/Joint

Muscular

Thinking/Cognition

Allergies

Consult a lawyer to ensure this form meets your state’s regulations. Take this form to your local emergency room to ensure that all pertinent information is present.

**MEDICATIONS** (include prescription and over-the-counter, name, dose and frequency)

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)

**PSYCHOSOCIAL FUNCTION** (e.g., 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?

Signature:

Date:

**PHOTO RELEASE**

I

 DO

 DO NOT

consent to and authorize the use and reproduction by

(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*

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2018

123