



Participants Application & Health History

General Information

Participant

Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Address: _____

Phone: _____ Email: _____ Alternate #: _____

Employer/School: _____

Parent/Legal Guardian: _____

Address (if Different from above): _____

Phone: _____

How did you find us? _____

Health History

Diagnosis: _____ Date of Onset: _____

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

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

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)

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

Goals (i.e., what would you like to accomplish?)

Signature: _____ Date: _____

PHOTO RELEASE

I **DO**
 DO NOT

Consent to and authorize the use and reproduction by Jericho's Gift of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, parent or legal guardian