



Cochise Area Network of Therapeutic Equestrian Resources, C.A.N.T.E.R.

PO Box 1316, Sierra Vista, AZ 85636

Participant's Application and Health History

GENERAL INFORMATION

Participant Name <input style="width:90%;" type="text"/>					
Height <input style="width:100px;" type="text"/>	Weight <input style="width:100px;" type="text"/>	Gender <input style="width:100px;" type="text"/>	D.O.B <input style="width:100px;" type="text"/>	Age <input style="width:100px;" type="text"/>	
Address <input style="width:350px;" type="text"/>		City <input style="width:150px;" type="text"/>	State <input style="width:50px;" type="text"/>	Zip <input style="width:100px;" type="text"/>	
Cell Phone <input style="width:150px;" type="text"/>	Home Phone <input style="width:150px;" type="text"/>	E-mail <input style="width:200px;" type="text"/>			

Employer/School <input style="width:250px;" type="text"/>	Address <input style="width:400px;" type="text"/>				
City <input style="width:300px;" type="text"/>	State <input style="width:50px;" type="text"/>	Zip <input style="width:100px;" type="text"/>	Phone Number <input style="width:150px;" type="text"/>		

Legal Guardian <input style="width:200px;" type="text"/>	Address <input style="width:450px;" type="text"/>				
City <input style="width:180px;" type="text"/>	State <input style="width:50px;" type="text"/>	Zip <input style="width:100px;" type="text"/>	Phone Number <input style="width:150px;" type="text"/>		

HEALTH HISTORY

Diagnosis <input style="width:500px;" type="text"/>	Date of Onset <input style="width:150px;" type="text"/>
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Conditions	Y	N	Comments
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	
Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Circulation	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	
Digestion	<input type="checkbox"/>	<input type="checkbox"/>	
Elimination	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional/Mental	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
Thinking/cognition	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICATIONS*(include prescriptions, over-the-counter medications, name, dosage, and frequency)*

Describe your abilities in the following areas. (Include assistance required or equipment needed.)

PHYSICAL FUNCTION*(i.e., mobility skills such as walking, wheelchair use, driving or bus riding)*

PSYCHO/SOCIAL FUNCTION *(i.e., work or education completed, interests, relationships, family structure, support systems, companion animals, fears, anxieties, etc.)*

GOALS *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 of any and all photographs and audio/visual materials taken of me by the Cochise Area Network of Therapeutic Equestrian Resources (CANTER) for promotional material, educational activities, exhibitions, or for any other use for the benefit of the program.

Referral Source

How did you hear about this program?

Signature (Client or legal guardian)

Date