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# Participant Application and Health History

## General Information

| | | | |
|---|---|---|---|
| Client Name: | | | D.O.B.: |
| Age: | Height: | Weight: | Gender: |
| Address: | | | |
| Phone: | | Email: | |
| Alternate phone: | | Emergency Contact: | |
| Person Completing form: | | | |
| Parent / Guardian: | | | |
| Address if different from above: | | | |
| | | | |

## Health History

Please add additional pages as needed

| | |
|---|---|
| **Diagnosis & Date of Onset:** | |
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| | |
| **Birth History:** | |
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| | |
| **Medical / Developmental History / Developmental Milestones:** | |
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| | |
| **Previous Intervention:** | |
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| | |
| **Current Intervention / Location:** | |
| | |

| | |
|---|---|
| **Medications (name, dose, frequency):** | |
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| | |
| | |
| **Insurance Provider:** | |

Please list any past or current challenges in the following areas:

| Area | Yes | No Concerns | Comments |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Touch / Sensation | | | |
| Movement | | | |
| Sensory Processing | | | |
| Communication | | | |
| Cognition | | | |
| Attention | | | |
| Cardiovascular / Heart | | | |
| Respiratory / Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Mental Health / Emotional | | | |
| Behavioral | | | |
| Pain | | | |
| Bones / Joints | | | |
| Muscular | | | |
| Allergies | | | |

## Function

| Primary Goal Areas / Reason for Seeking Services: |
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| |

**Physical Function and Mobility (please list concerns)**

| Area | Yes | No Concerns | Comments |
|---|---|---|---|
| Walking | | | |
| Transfers out of bed | | | |
| Transfers out of chair | | | |

| Area | Yes | No Concerns | Comments |
|---|---|---|---|
| Transfer in / out of car | | | |
| Transfers in tub / shower | | | |
| Transporting items | | | |
| Able to maintain balance for dressing | | | |
| Running, jumping | | | |
| Bike riding | | | |
| Other: | | | |

**Psychological and Social Function and History (please list areas of concern)**

| Area | Yes | No Concerns | Comments |
|---|---|---|---|
| Mental health diagnosis | | | |
| Support systems | | | |
| Family structure | | | |
| School or work | | | |
| Relationships with others / friendships | | | |
| Ability to care for others (people / animals) | | | |
| Play / leisure | | | |
| Other: | | | |

## Daily Activities, Occupational History, Learning Style

### Communication

| Area | Yes | No Concerns | Comments |
|---|---|---|---|
| Expressive language – age appropriate | | | |
| Receptive language-age appropriate | | | |
| Uses visual aids | | | |
| Follows 1 step directions | | | |
| Follows 2-3 step directions | | | |

### Learning Style

| Please list preferred learning supports. Describe any adaptations or concerns. |
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**Grooming / Hygiene**

| Status | Bathing / showering | Brushing / styling hair | Brushing teeth | Washing hands | Nasal care / blows nose |
|---|---|---|---|---|---|
| Independent | | | | | |
| Assistance Required | | | | | |
| Describe: | | | | | |

**Toileting** (please check)

| Age appropriate | Assistance required | Requires medication | Area of concern |
|---|---|---|---|
| Describe: | | | |

**Regulation / Sleep**

| **Area** | **Yes** | **No** | **Comments** |
|---|---|---|---|
| Falls asleep Independently | | | |
| Naps | | | |
| Wakes during night | | | |
| How many hours of sleep per day? | | | |
| Describe: | | | |

**Play / Leisure**

| Please list preferred free time activities. Describe any adaptations or concerns. |
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**School / Work**

**Educational level completed:**

| Please describe school or work. Describe any adaptations or concerns. |
|---|
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| |

## PHOTO RELEASE

**I DO ☐** or **I DO NOT ☐**

Consent to and authorize the use and reproduction of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibits, possible use on website, or for any other use for benefit of the program.

Signature: _____ Date:_____

Client, Parent or Legal Guardian

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## EMERGENCY TREATMENT RELEASE

| | | |
|---|---|---|
| Physician: | | Phone: |
| Physician Address: | | |
| Preferred Medical Facility: | | |
| Health Insurance: | | |
| Insurance Policy Number: | | |

Emergency Contact Information:

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |
| | | |

☐ **I GIVE MY CONSENT**, in the event of a medical emergency, for Making Strides LLC to provide such medical assistance as deemed to be necessary. I authorize any licensed physician and/or medical facility to provide medical surgical care and/or hospitalization for the above-named volunteer, including anesthetic, which they determine to be necessary or advisable, pending receipt of a specific consent from the undersigned.

☐ **I DO NOT GIVE MY CONSENT** for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of / used by the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Signature: _____ Date: _____

Client, Parent or Legal Guardian