FULL CIRCLE FARM
THERAPEUTIC HORSEMANSHIP

80 Edgell Road
Newport, NH 03773

603.863.1262
info@fcftherapeutic.org

fcftherapeutic.org

Participant's Application & Health History

Participant: ____
DOB: _______________ Age: ___________ Ht: ____________ Wt (180 max): ______________ Gender: M F
Address: ____
Email: __________________________ Phone: ______________________ Cell: ______________________
Employer/School:____
Address:____ Phone: ___________________________________
Parent/Legal Guardian:____
Caregivers:____
Address (if different):____Phone:__________________________
Referral Source:____Phone:__________________________
How did you hear learn of our program?____

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 (including assistance required or equipment needed):

PHYSICAL FUNCTION (e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

PSYCHO/SOCIAL 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 ☐ I DO NOT

consent to and authorize the use and reproduction by Full Circle Farm of any and all photographs and any other audio/visual materials taken of participant and/or 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