Aeroflex Equine Therapy

CLIENT PARTICIPATION APPLICATION

NAME:				
TODAY'S DATE:				
PARENT/GUARDIAN:				
PRIMARY PHONE:				
DOB:	AGE:	HEIGHT:	WEIGHT:	GENDER: ☐ M ☐F☐ ☐UNSPECIFIED

DIAGNOSIS:	
DATE OF ONSET:	
PAST/PROSPECTIVE SURGERIES:	
MEDICATIONS:	
ALLERGIES:	
SEIZURE TYPE:	
CONTROLLED: ☐Yes ☐No	DATE OF LAST SEIZURE:

In the last 12 months, has participant:

Experienced loss of consciousness, including seizures?	**☐Yes ☐No**
Experienced a psychotic crisis?	**☐Yes ☐No**
Been hospitalized for serious injury, condition, or surgery?	**☐Yes ☐No**
Had a restriction of activities due to medical reason?	**☐Yes ☐No**
Does the participant need assistance to maintain an upright sitting position or to control his/her head?	**☐Yes ☐No**

For those with Down Syndrome:

Atlantoaxial Instability Date:	RESULT: ☐Positive ☐Negative