

STABLE MOVEMENTS
18 SMITH HILL RD
BINGHAMTON N.Y. 13905

Participant's Application and Health History

GENERAL INFORMATION

Participant:

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the 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

(over)

9/00

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency)

Describe your abilities/difficulties in the following areas (include assistance required or equipment needed):

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

PSYCHO/SOCIAL FUNCTION (i.e. 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?)

PHOTO RELEASE

I DO
DO NOT

consent to and authorize the use and reproduction by **Stable Movements** of any and all photographs and any other audio/visual materials taken of 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