New Heights Therapy and Riding

PARTICIPANT APPLICATION

Participant's Name_____ Date of Birth_____ Age___
Male__ Female__
Street_____ City_____ State___ Zip_____
School Name_____
Parent or Guardian Name(s)_____
Home Phone_____ Cell Phone_____ Work Phone_____

How did you hear about our program?_____

Does your child currently receive therapy services? _____ If yes, what services?_____ Name of therapist and organization
_____

Please describe limitations/ concerns in the following areas:

Physical Function (e.g. ambulation, motor skills, balance, strength, tone, vision):
_____
_____
_____

Cognition and Processing (e.g. attention, touch/sensation, memory, speech and language, sensory integration, learning disabilities, developmental delays):
_____
_____
_____

Psychological, emotional, behavioral, social issues:
_____
_____

Does your child have any previous hippotherapy or riding experience? If so, please describe:
_____
_____