



Health History

Please complete this form as accurately as possible so we can best serve your family. All information is confidential.

Please mark any current or past problems in the following areas:

- Thinking/Cognitive _____
- Behavioral _____
- Emotional _____
- Communication _____
- Sensation _____
- Hearing _____
- Vision _____
- Muscular _____
- Bone/Joint _____
- Pain _____
- Circulation _____
- Elimination _____
- Digestion _____
- Breathing _____
- Cardio _____
- Allergies _____

Current Medications of Applicant (include over-the counter):

Please note any Mental, Physical or Emotional diagnoses of Applicant:

Is Applicant currently under the care of the Therapist/ Psychologist? Yes / No

If yes, Name: _____

Any Current Diagnosis? _____

Assault or Aggressive Behavior? _____

Does Applicant have any mental/ physical limitations? _____

Does Applicant have any trauma/triggers/phobias? _____

Is there any history of animal abuse? _____

Any Addition information please add here:

***Please note if the applicant has special needs there is an additional form to fill out.