

Walk On Health History Participant

General Information:

Name: _____ Date: _____

Diagnosis: _____

Date of Onset: _____ Age: _____ Medications: _____

Please indicate current or past specials needs in the following areas:

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Cardiac			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional/ Mental Health			
Behavior			
Pain			
Bone/Joint			
Muscular			
Cognition/Thinking			
Allergies			

Strengths: _____

Concerns: _____

Goals: _____

I understand that the information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

Participant,, parent, guardian; signed in presence of center staff