



1140 16th Street West, #12
Billings Montana, 59102
(406) 969-2949

Participant Packet & Medical History

Participant Information

(To be completed in full)

Name: _____ Today's Date ___/___/___ Date of Birth ___/___/___

Gender: ___ Age: ___ Height: ___ FT ___ Inches Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Military Service: None Current Former/Branch: Dates-Served:

Is the Participant their own guardian: Yes No

Emergency Contact Information:

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Parent/Guardian/Caregiver Information:

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

General Information:

Favorite Activities or Topics: _____

Any Fears or Dislikes: _____

Family Do's & Don'ts: _____

Anything Else We Should Know: _____

Diagnosis-Primary: _____ **Diagnosis-Secondary:** _____

Date of Onset: _____ Primary Language spoken/understood: _____

Have there been any seizures in the last year? ___ **Yes** ___ **No** Seizure Type: _____

Most recent date: _____ Are they controlled: ___ **Yes** ___ **No**

Allergies: _____ No Concerns: _____

(Please list all known Allergies, Reactions, and Medications)

Medical Information: List all medications the participant is currently taking. Attach additional pages if needed.

___ **No Concerns** (If no concerns, continue to Dietary)

Medication	Schedule	Reason	Side Effect

Will the participant be taking medications during the scheduled program ___ **Yes** ___ **No**

Does the participant ever experience altitude sickness ___ **Yes** ___ **No** ___ **Not Sure**

Does the participant ever experience motion sickness ___ **Yes** ___ **No** ___ **Not Sure**

Dietary Restrictions: _____
(List any food restrictions.)

No Concerns: _____

Past/Prospective Surgeries: _____

No Concerns: _____

Please check the most appropriate answer:

Dressing: ___ **Independent** ___ **Partial Assist** ___ **Total Assist**

Eating: ___ **Independent** ___ **Partial Assist** ___ **Total Assist**

Toileting: ___ **Independent** ___ **Partial Assist** ___ **Total Assist**

Bladder Control: ___ **Normal** ___ **Occasional** ___ **Incontinent**

Bowel Control: ___ **Normal** ___ **Occasional** ___ **Incontinent**

Will a caretaker be attending with the participant: ___ **Yes** ___ **No**

Physical Concerns: **No Concerns**

Sits Unassisted: Yes No If yes, for how long? _____

Stands Unassisted: Yes No If yes, for how long? _____

Runs Unassisted: Yes No

Walks Unassisted Yes No

Uses hands independently Yes No

Bears weight on hands: Yes No

Climbs stairs: Yes No

Bears weight on legs Yes No

Primary Means of Mobility: Power Wheelchair Manual Wheelchair Cane Walker Other

Braces/Assistive Devices: _____

Transfers: No Assist Partial Assist Total Assist

Endurance: Average Fair Poor

Describe general balance: _____

Describe Fine Motor Skills: _____

Concerns with Muscle spasms/tightness: _____

Concerns with temperatures: _____

Concerns with Pressure Sores/Skin Breakdowns: _____

Extra sensitive to the sun: Yes No

Spinal Stabilization: Yes No If Yes, Location: _____ Fusion or Fixed Device

Shunt/Catheters: Yes No Date of last revision: _____

Hand/Eye Coordination: Average Fair Poor

Sensory Concerns: **No Concerns**

Vision:

Partially Sighted/Legally Blind Complete Blindness

Please describe the amount of vision the participant has: _____

Hearing:

Partial Hearing Loss Total Hearing Loss

Please describe how the participant best communicates: _____

What sensory situations upset him/her? _____

Please describe sensitivities in the following areas:

Visual (seeing): _____

Auditory (hearing): _____

Olfactory (smelling): _____

Tactile (touching): _____

Proprioceptive (movement): _____

Cognitive and Processing: Is the participant proficient in the following skills? (Mark an X if applies)

Educational:

___ Knows Numbers

___ Knows Letters

___ Knows left/right

___ Knows prepositions

___ Communicates feelings

___ Makes choices

Language:

___ Makes sounds

___ Says Words

___ Combines 2 or more words

___ Speaks in complete sentences

___ Understands "No"

___ Letter sound identification

___ Signs or uses gestures

___ Uses picture symbols

Social:

___ Recognizes Name

___ Makes Eye Contact

___ Waves: Says hi/bye

___ Shares toys/items

___ Knows safety awareness

___ Interacts with peers

___ Appropriate conversation

___ Takes turns

___ Understands personal space

Follows Direction: ___ 1-step ___ 2-step ___ 3-step ___ Complex Attention

Attention To Task: ___ Poor (0-1 minute) ___ Fair (1-5 minutes) ___ Average (5 minutes)

Frustration Tolerance: ___ Poor ___ Fair ___ Average

Problem Solving: ___ Poor ___ Fair ___ Average

Learning Style: ___ Visual/Learns by seeing ___ Auditory/Learns by hearing ___ Kinesthetic/learns by doing

Behavioral: (Mark X if applies) ___ No Concerns

Please explain any behavioral issues:

Shows violence: ___ Yes ___ No If Yes, please explain: _____

Successful Intervention Strategies used (behavioral rewards, consequences, etc...)

Program Specific

Is the Participant capable of:	Y	N	Has he/she participated in any of the following activities in his/her state of health	Y	N
Swimming Independently?			Canoeing/Kayak/Stand-up Paddle Board		
Independently lift arms above head?			Rock climbing		
Independently rolling over if face-down in water?			Aquatics		
Independently grasping a rope?			Nordic Skiing/Snow Shoeing		
Physically signaling for help?			Water Skiing		
Yelling for help?			Archery		
Can communicate pain?			Sled Hockey		

State the participant's experience in the following sports. Please include type of equipment used (Adaptive/Non-Adaptive).

Can the participant ride a bike? Yes No

If yes, what type? Bicycle Tricycle Recumbent Hand Cycle Other

Has the participant ridden a horse? Yes No

If yes, what kind? Pony Ride Western English Trail Ride

Is Assistance needed? Yes No If Yes, what kind? Lead Walker Side Walker Not Sure

Has the participant alpine (downhill) skied before? Yes No

If yes, what kind? **Stand:** Typical Skis Snowboard Ski Walker Other

Sit: Bi-Ski Mono-Ski

Skill Level: Never Ever Beginner Intermediate Advanced

Has the participant Nordic (cross-country) skied or snow shoed before? Yes No

If yes, what kind? Nordic Ski (Stand) Nordic Ski (Sit) Snowshoe

Has the participant engaged in Paddle Sports before? Yes No

If yes, what kind: Stand up Paddleboard Kayak Canoe

The participant's ability to get up independently after falling: Total Assist Partial Assist No Assist

Needs a consistent instructor: Essential Preferred Not Necessary Instructor: _____

Name any other adaptive programs he/she has participated in:
