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:

_____

_____

Once you have filled out this form, save to your computer to be able to attach to an email. Send to cindam@eaglemount.us