



**Colorado Therapeutic Riding Center, Inc.**  
**11968 Mineral Road, Longmont, CO 80504**  
**(303) 652-9131 FAX (303)652-2072 www.ctrcinc.org**

## PARTICIPANT APPLICATION

**In order to ensure coordinated care, CTCRC staff and volunteers are provided with information about participant's abilities/disabilities.**

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Male  Female  Race/Ethnicity(optional) \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ County \_\_\_\_\_

Email address: \_\_\_\_\_

School Name \_\_\_\_\_

Parent or Guardian Name(s) \_\_\_\_\_

Rider or Guardian's Employer \_\_\_\_\_

Diagnosis: Primary \_\_\_\_\_ Secondary \_\_\_\_\_

List Phone Numbers and whose number it is, if other than Participant:

Home # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_

Work # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_

Cell # \_\_\_\_\_ If not Participant's #, whose is it? Name: \_\_\_\_\_

How did you hear of our program? \_\_\_\_\_

Do you have previous riding experience? If so, please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_

### Physical skills

Is the participant proficient in the following skills? Mark X for yes:

<input type="checkbox"/>	Sits unassisted
<input type="checkbox"/>	Stands independently
<input type="checkbox"/>	Walks unassisted
<input type="checkbox"/>	Runs unassisted

<input type="checkbox"/>	Uses hands independently
<input type="checkbox"/>	Releases object
<input type="checkbox"/>	Bears weight on hands

<input type="checkbox"/>	Uses bathroom independently
<input type="checkbox"/>	Climbs stairs
<input type="checkbox"/>	Bears weight on legs

Describe General Balance: \_\_\_\_\_

Please list and explain ANY assistive devices that the participant may use at home or school:  
 \_\_\_\_\_  
 \_\_\_\_\_

Notes on Hearing or Vision Impairments: \_\_\_\_\_

Hand Preference:  Left  Right  No Preference

### Sensory

Please describe any sensitivities in the following areas:

Visual (seeing): \_\_\_\_\_

Auditory (hearing): \_\_\_\_\_

Olfactory (smelling): \_\_\_\_\_

Tactile (touching): \_\_\_\_\_

Proprioceptive (movement): \_\_\_\_\_

**Cognition and Processing:**

No Concerns (If there are no concerns in any of the following areas, please skip ahead to Personality Profile)

If there are concerns in the area of cognition and processing, please complete the following:

Is the participant proficient in the following skills? Mark X for yes:

EDUCATIONAL/COGNITIVE	
<input type="checkbox"/>	Knows numbers
<input type="checkbox"/>	Knows letters
<input type="checkbox"/>	Knows left/right
<input type="checkbox"/>	Knows prepositions
<input type="checkbox"/>	Communicates feelings
<input type="checkbox"/>	Makes choices

SOCIAL	
<input type="checkbox"/>	Recognizes name
<input type="checkbox"/>	Makes eye contact
<input type="checkbox"/>	Waves/ says hello/bye
<input type="checkbox"/>	Shares toys/items
<input type="checkbox"/>	Knows safety awareness
<input type="checkbox"/>	Interacts with peers
<input type="checkbox"/>	Appropriate conversation
<input type="checkbox"/>	Takes turns

LANGUAGE	
<input type="checkbox"/>	Makes sounds
<input type="checkbox"/>	Says words
<input type="checkbox"/>	Combines 2 or more words
<input type="checkbox"/>	Speaks in complete sentences
<input type="checkbox"/>	Understands "No"
<input type="checkbox"/>	Letter sound identification
<input type="checkbox"/>	Signs or uses gestures
<input type="checkbox"/>	Uses picture symbols

Follows Direction: 1 Step \_\_\_ 2 Step \_\_\_ 3 Step \_\_\_ Complex \_\_\_

Attention to task: Poor (0-1 min) \_\_\_ Fair (1-5 min) \_\_\_ Avg (5 min) \_\_\_

Frustration Tolerance: Poor \_\_\_ Fair \_\_\_ Avg \_\_\_

Problem Solving: Poor \_\_\_ Fair \_\_\_ Avg \_\_\_

**Personality Profile**

Please describe personality and strengths: \_\_\_\_\_

What are some favorite activities or topics? \_\_\_\_\_

What are some fears or dislikes? \_\_\_\_\_

Psychological, emotional, behavioral, social issues: \_\_\_\_\_

Learning Style, please circle: Visual/learns by seeing Auditory/learns by hearing Kinesthetic/learns by doing

Successful Intervention Strategies used (sensory modalities, behavioral, rewards, etc.):

Our Family's Do's and Don'ts: \_\_\_\_\_

Any other special things we should know?

Please list any goals (i.e. what would you like to accomplish in therapeutic riding/hippotherapy?):

This form was completed by (participant/parent/other): \_\_\_\_\_

\*Please attach additional sheets of paper or more information (i.e. IEP) if desired

\*Feel free to enclose a photo for your file