



*Michigan Abilities Center*  
 7286 W. Ellsworth Road, Ann Arbor, MI 48103  
 Phone: (734) MAC-9500 Fax: (734) MAC-9555  
 Website: MichiganAbilitiesCenter.org

## Participant's Health History

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

Diagnosis/Disability \_\_\_\_\_ Date of Onset \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair: Y N

Braces/Assistive Devices: \_\_\_\_\_

**Participant, parent or guardian – please indicate current or past problems in the following areas:**

	Y	N	Comments
Auditory			
Vision			
Sensation			
Coordination			
Balance (sitting &/or standing)			
Communication			
Activities of Daily Living			
Heart			
Circulation			
Breathing			
Digestion			
Elimination			
Skin breakdown			
Immunity			
Muscular			
Bone/Joint			
Pain			
Learning disability			
Cognition/ Thinking			
Emotional/Mental Health			
Behavioral			
Other			
Allergies			
Other (specify)			

List your current medications (prescription and over-the-counter medications) & indicate the dose & frequency.

\_\_\_\_\_

Describe your abilities/difficulties in the following areas (include assistance required &/or equipment needed)

PHYSICAL FUNCTION (i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

\_\_\_\_\_

PSYCHOSOCIAL (i.e. work/school-including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.) \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

(Participant, Parent or Guardian)