

EquusTherapyWorks

Horses Changing Lives

*This form is for equine-assisted psychotherapy clients only.

Client's Name _____ Date of Birth _____ Age _____ Gender _____

Address _____ City _____ State _____ Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____ Email _____

___ Okay to leave message ___ Do NOT leave message ___ Do NOT call or contact

Marital Status _____ Client Occupation _____

In case of emergency, contact _____ Phone _____

What kind of counseling do you prefer? ___ Individual ___ Couples ___ Family
___ Group

Level of Education _____

List the members of your current family in order of their age, beginning with the oldest:

Name	Age	Gender	Education
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had problems with eating, sleeping, disease, serious injury, other? If so, please explain _____

Name of your primary care physician _____ Date of last physical _____

Is there any medical reason that you cannot take part in activities associated with equine-assisted therapy? _____

Have you every consulted a psychiatrist or been hospitalized for psychological reasons? If so, please describe _____

Please list any medications you are taking for psychological reasons? _____

What issue(s) bring you to counseling? When were you first aware that you needed help with this issue? _____

Other agencies or individuals from whom you have received or are now receiving counseling:

Name	Address	Date
_____	_____	_____

** For clients under the age of 18

If parents are divorced, both signatures are required or you can provide a court document that indicates that you have the right to seek counseling for the child.

Parent Signature

Parent Signature