Horses Guiding Humans

"Take life in stride!"

Client Information form

Today's Date:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Client's Name:_____

Address: City: State: Zip:

Email:

Age: Date of Birth: Place of birth:

Male: Female: Single: Married: Divorced: Widowed:

Referred by:

Where would you like me to leave message:

If there is an emergency and we must cancel your appointment, where should we call:

Employer: Occupation:

Why are you seeking counseling?

When did you feel this concern first started? Within the last: 30 Days 6-12 Months

During adolescence During Childhood

What areas of your life have been affected because of this concern?

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

Please describe any major losses or traumas you have experienced:

What significant life changes or stressful events have you experienced recently?

What would you like to accomplish out of your time in therapy?

Have you previously received any type of mental health services? Yes No

If yes, please explain:

Name of previous provider or facility: _____

Location: _____

Dates of treatment: _____ Reason for treatment: _____

_____

Are you seeking counseling else-where? _____

Family History

Do you identify with any ethnic or cultural background? _____

Where did you grow up? City Suburbs Country Other: _____

Please list your parents and siblings:

_____

_____

_____

Who did you live with growing up? _____

Mothers Occupation: _____ Fathers Occupation: _____

Is there a family history of the following?

Alcohol/Substance Abuse	Yes/No	Family Member:_____
Anxiety	Yes/No	Family Member:_____
Depression	Yes/No	Family Member:_____
Domestic Violence	Yes/No	Family Member:_____
Sexual Abuse	Yes/No	Family Member:_____
Eating Disorders	Yes/No	Family Member:_____
Obesity	Yes/No	Family Member:_____
Obsessive Compulsive	Yes/No	Family Member:_____
Behavior	Yes/No	Family Member:_____
Schizophrenia	Yes/No	Family Member:_____
Suicide Attempts	Yes/No	Family Member:_____
Other:_____	Yes/No	Family Member:_____

Who lives with you?

About You

Where did you attend school?

Did you attend college? When? Where?

About Your Health

Who is your doctor? When was your last visit?

Any concerns shared by your doctor?

Describe any allergies you have:

Do you have any chronic medical concerns?

Please list them:

Do you have a Mental Health Diagnosis? If so, which one?

Are you under the care of a psychiatrist? If so, whom?

Have you been prescribed any psychotropic drugs by your psychiatrist? If so, please list:

Please list all medications or drugs (legal or illegal) you have taken in the past year:

List all diseases, illnesses, important accidents and injuries, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have or have had:

How would you rate your overall health?	Poor	Unsatisfactory	Satisfactory
	Good	Very Good	
Please rate your current sleeping habits:	Poor	Unsatisfactory	Satisfactory
	Good	Very Good	