WARHORSE RANCH

D A T E :

_____

**CLIENT INTAKE FORM**

*Please have the individual receiving services complete the form. If there will be more than one individual in your family receiving services, please complete one form per person.*

Name:_____

Date of Birth:_____ Age:_____

Address_____

City_____State_____Zip_____

Phone Number: _____

Email Address:_____

What is the best way to contact you? _____

Can we leave a message?

_____

Can we communicate scheduling changes over text?

_____

Who else lives with you?

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Any children or close family members no longer living at home?

(names and ages)

_____

Languages spoken at home:_____

Are you currently working with a counselor or therapist? If yes, please provide the following:

Provider's
Name:_____

Provider's Phone Number:

_____

How long have you been working with this provider?

_____

How often do you meet with this provider?

_____

*If you are working with multiple providers, please include it on page three under outpatient treatment.*

**Reason that you are here:** Briefly describe the challenges(s) for which you are seeking help through Equine Assisted Therapy:

_____

_____

When did the problem start?

_____

Has something in particular happened or changed recently that led you to seek professional assistance at this time?

_____

_____

**Current Symptoms Checklist:** (check once for any symptoms present within the last month, leave empty if not relevant)

( ) Depressed mood
( ) Racing thoughts
( ) Excessive worry
( ) Unable to enjoy activities
( ) Impulsivity
( ) Anxiety attacks
( ) Sleep pattern disturbance
( ) Risky behavior
( ) Avoidance
( ) Loss of interest

( ) Grieving/Loss
( ) Concentration/ Forgetfulness
( ) Difficulty with relationships/ friendships ( ) Suspiciousness
( ) Change in appetite
( ) Excessive energy
( ) Excessive guilt
( ) Increased irritability

( ) Fatigue
( ) Crying spells
( ) Compulsive behavior
( ) Substance use/abuse
( ) Hallucinations
( ) _____
( ) _____
( )

Did /does anyone in your family of origin (your parents and siblings) or your spouse/partner's family of origin have any mental health concerns? Explain briefly.

_____

_____

Describe briefly any serious medical problems or major surgeries in your history.

_____

_____

Are you currently taking any medication? If so, what is it, what is it for, and who prescribes it?

_____

Current medical concerns (please specify):

**Past Psychiatric History**: Have you ever received a mental health related diagnosis? ( ) Yes ( ) No *If yes, Please describe and include which provider made the diagnosis:*

Outpatient treatment ( ) Yes ( ) No *If yes, Please describe when, by whom, and nature of treatment. This can include speech therapy, art therapy, mentoring, etc. You do not need to repeat the provider you listed on page 1.*

Provider's name Type of Treatment When did it begin & Frequency of treatment

Psychiatric Hospitalization ( ) Yes ( ) No *If yes, describe for what reason, when and where.*

Reason Dates Hospitalized Facility

**Past Psychiatric Medications:** If you have ever taken any psychiatric medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember). Please include any current psychiatric mediations you are prescribed.

Medication Name Total Daily Dosage Estimated Start and End Date

**Your Exercise Level**:

Are you happy with the amount of exercise you get? ( ) Yes ( ) No

Please describe your typical method and frequency of exercising:

_____

_____

_____

**Substance Use**:

How often do you consume alcohol?

_____

How much do you consume when you drink alcohol?

_____

How often do you use other substances (marijuana or cocaine for example)?

_____

Do you have concerns with your current alcohol or drug use? ( ) Yes ( ) No

Have you ever been treated for alcohol or drug use? ( )

Yes ( ) No

If yes, for which substances?

_____

If yes, where were you treated and when?

_____ Have you ever used prescription medication in a way other than how it was prescribed or used prescription medication that was not prescribed for you?

( ) Yes ( ) No *If yes, please describe:*

_____

**Family Background and Childhood History:**

Were you adopted? ( ) Yes ( ) No

Where did you grow up?

_____

List your siblings and their ages:

_____

_____

What is/was your father's occupation?

_____

What is/was your mother's occupation?

_____

Who in your family do you feel closest to?

_____

Do you have any pets? If yes, describe:

_____

Did your parents divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

Has anyone important to you recently died?

_____

How does your family manage conflict? Please describe:

_____

_____

How would you describe your family?

_____

_____

_____

_____

Have you ever experienced abuse either emotionally, sexually, physically or by neglect?

( ) Yes ( ) No.

Do you feel that this experience still impacts you day to day living? ( ) Yes ( ) No

*If yes, please describe:*

_____

_____

Have you ever been directly exposed to a traumatic event that involved actual or threatened death, serious injury or violence? ( ) Yes ( ) No.

Do you feel that this experience still impacts you day to day living? ( ) Yes ( ) No

*If yes, please describe:*

_____

_____

**Educational & Occupational History:**

Are you currently attending school?

Highest Grade Completed? _____

Where? _____

Did you attend college? _____ Where? _____

Major? _____

Are you currently working: ( ) Full Time ( ) Part Time ( ) Unemployed ( ) Disabled ( ) Retired

Where do you work? _____

Do you enjoy your work? _____

Have you ever served in the military? _____

**Relationship History and Current Family**:

Are you currently: ( ) Married ( ) Partnered ( ) Separated ( ) Divorced ( ) Single ( )Widowed

Do you feel that your relationship status is impacting your current functioning? ( ) Yes ( ) No.

Please describe:

_____

**Spiritual Life:**

Do consider yourself to be religious or spiritual? ( ) Yes ( ) No

Do you feel that your spiritual views have a significant impact on your daily life? ( ) Yes ( ) No

Please describe:

_____

**Experience with horses:** Have you had any prior experience with horses?

( ) No ( ) Yes If Yes, please describe:

( ) occasional pony rides ( )grew up around horses ( ) took riding lessons

( ) experienced rider

Have you ever participated in an equine assisted psychotherapy (EAP)?

( ) Yes ( ) No If yes, when, how long, and did you find it helpful?

_____

**Is there anything else that you would like us to know?**

_____

_____

_____

_____

Who can we contact in the event of an emergency? Please give name with home and work numbers.

Emergency Contact: _____

Relationship: _____

Phone Number:_____

REFERRED BY: _____

Client Signature: _____ Date:_____