HIGHER GROUND HEALING
Equine Assisted Therapy

DEMOGRAPHICS INTAKE

Today's Date: _____ Client's Name: _____

Client's DOB: _____ Phone Number: _____

Home Address: _____

Referral Source: _____

Emergency Contacts Phone Number/Name:

_____ _____

_____ _____

_____ _____

Primary Guardian's First and Last Name: _____

If client is under 18, do you have a joint custody? If so, do you have sole decision making?
Are there any other court orders to be aware of?

_____

_____

_____

Reason for Beginning Therapy: _____

_____

_____

_____

Current Therapy goals: _____

_____

_____

_____

How would you know that therapy was helpful for the client if you look back after the experience?

_____

_____

On a scale of 1-10 please rate the following related to Client.
(1 represents the lowest amount of disturbance and 10 represent the highest amount.)

Depression: 1 2 3 4 5 6 7 8 9 10

Anxiety: 1 2 3 4 5 6 7 8 9 10

Current Level of Suicidal ideation: 1 2 3 4 5 6 7 8 9 10

Rate your overall level of satisfaction in life: 1 2 3 4 5 6 7 8 9 10

Does the client have a psychiatrist? Yes ☐ No ☐

Name: _____

Any history of medical or psychiatric hospitalizations? _____
If so, how many and where?

_____

_____

MEDICAL HISTORY

Primary Care Provider _____ Phone Number _____

Date of last visit? _____

Would you like us to inform your medical provider of the therapy your child receives here? Yes ☐ No ☐

Is there a past or present history of substance abuse? Please explain:

_____

_____

Please list any history of family members with previous mental health diagnosis:

_____

_____

_____

_____

Please list any Prescription Medications: (Include Dosage and Duration):

_____

_____

_____

_____

Please describe the most concerning symptoms client has experienced in the last 3 months.

_____

_____

_____

_____

What would you say is the biggest reason in your opinion your child has been struggling?
Please list any recent triggers.

_____

_____

_____

_____

_____

How could either individual or group therapy be most helpful to your child at this time?

Has your child had previous positive or negative experiences with counseling?
If so please describe what was helpful or hurtful in your opinion: