Equine Assisted Therapy -- Intake Inventory

CLIENT INFORMATION	FAMILY/SPOUSE INFORMATION
Name: _____ Sex: F M Address: _____ City, Zip: _____ Home Phone: _____ Cell Phone: _____ Employer: _____ SS#: _____ DOB: _____ Age: ___ Married Remarried Single Separated Divorced Court Involvement: _____ Other Agencies Involved: _____ _____	Spouse/Parent: _____ Address: _____ City, Zip: _____ Home Phone: _____ Cell Phone: _____ Employer: _____ SS#: _____ DOB: _____ Age: ___ Married Remarried Single Separated Divorced

Education: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+
Other (list type and years): _____
Information on children –

Name:	Age:	Sex:	Living:		School Grade:
_____	_____	**M F**	**In Home**	**Out of Home**	_____
_____	_____	**M F**	**In Home**	**Out of Home**	_____
_____	_____	**M F**	**In Home**	**Out of Home**	_____
_____	_____	**M F**	**In Home**	**Out of Home**	_____

PARENTAL CONSENT

MUST BE COMPLETED FOR ALL CLIENTS UNDER AGE OF 18

I, legal guardian, give my authorization for EAP Services to counsel with the above mentioned minor.

Signature: _____ Date: _____

HEALTH

How would you rate your physical health? Very Good Good Average Poor
If you are presently taking any medication, please list: _____
For what condition: _____ PCP contact info:_____
Name of referring Physician, if any: _____

THERAPY HISTORY

How did your hear about Special Spirit EAP Services?
Friend Family Member Phone Book Brochure Other: _____
How you ever been see or treated by a psychiatrist or therapist? Yes No
If yes, how long: _____
Please state in a few sentences the major therapy need you have at this time:
_____
_____
_____
_____