

Client Information Form

Please mail to: Northland Therapeutic Riding Center, P.O. Box 1267, Kearney, MO 64060

MENTAL HEALTH DATA (Please complete if applicable.)

Client's Name: _____

Age: _____ DOB: _____ Sex: Male ___ Female ___ Height: _____ Weight: _____

Parent/Guardian name (If under 18 years): _____

Parent/Guardian Phone: Home Phone: _____ Work Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Physician's Name: _____ Physician's Phone: _____

Therapist's Name: _____ Therapist's Phone: _____

Diagnosis (DSM-IV): Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Presenting Problems: _____

Current medications:

Drug	Dose	Route	Time	Purpose
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatric Treatment History:

	Where	When	Diagnosis
Current Therapy	_____	_____	_____
Outpatient Therapy	_____	_____	_____
Inpatient Therapy	_____	_____	_____

Therapeutic and Safety Issues _____

Check and describe applicable issues (indicate current or history of):

Comments

<input type="checkbox"/> Inattention	_____
<input type="checkbox"/> Hyperactivity	_____
<input type="checkbox"/> Lack of concentration	_____
<input type="checkbox"/> Learning disabilities	_____
<input type="checkbox"/> Developmentally delayed	_____
<input type="checkbox"/> Mentally challenged	_____
<input type="checkbox"/> Boundary issues	_____
<input type="checkbox"/> Social skills problems	_____
<input type="checkbox"/> Problem with peers	_____
<input type="checkbox"/> Separation anxiety	_____
<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Phobias	_____
<input type="checkbox"/> Aggressive	_____
<input type="checkbox"/> Assaultive	_____
<input type="checkbox"/> Manipulative	_____
<input type="checkbox"/> Unpredictable or dangerous behavior	_____
<input type="checkbox"/> Sensory impairment	_____
<input type="checkbox"/> Sensitivity, preferences	_____
<input type="checkbox"/> Tics or stereotypic behavior	_____
<input type="checkbox"/> Psychosomatic symptoms	_____
<input type="checkbox"/> Medical issues	_____
<input type="checkbox"/> Self-injurious behavior	_____
<input type="checkbox"/> Suicidal ideations	_____
<input type="checkbox"/> History of runaway	_____
<input type="checkbox"/> Issues of parental support	_____
<input type="checkbox"/> Issues of family support	_____
<input type="checkbox"/> Sexual abuse/acting out	_____
<input type="checkbox"/> History of physical	_____
<input type="checkbox"/> Emotional abuse	_____
<input type="checkbox"/> Hallucinations	_____
<input type="checkbox"/> Delusions	_____
<input type="checkbox"/> Illusions	_____
<input type="checkbox"/> Dissociations	_____
<input type="checkbox"/> Substance abuse problems	_____
<input type="checkbox"/> Legal problems	_____
<input type="checkbox"/> School problems	_____
<input type="checkbox"/> History of animal abuse and/ or fire setting	_____
<input type="checkbox"/> Seizure disorder	_____
<input type="checkbox"/> Possible medication side effects	_____

Information Source: _____

Date Form Completed: _____