



Client Information

Date: _____

Client: _____

Date of Birth: _____ Age: _____

Address: _____

Parents or Guardian: _____

Address: _____

Daytime Phone (HOME/WORK): _____

Evening Phone (HOME/WORK): _____

Email Address: _____

School or Facility presently attending, Grade, Teacher: _____

IEP/504 plan? Yes/No

If Yes, what is the identified target concern?

Medications (include prescription and over-the-counter with names, frequency and dosage):

Current or past medical concerns:

Allergies: _____

Primary Care Physician, name, address, phone number:

Emergency contact and relationship: _____

Phone: _____

Secondary Contact and relationship: _____

Phone: _____

Have you or your child had any experience with a horse? Please describe when, where, response:

