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Thank you for your interest in Adirondack Equine Assisted Psychotherapy. Please complete the following form and contact me with any questions. Thank you.

Date: _____

Source of Referral:_____Phone Number:_____
Address:_____Fax Number:_____

Primary Therapist:_____Phone Number_____
Address:_____Fax Number:_____

Case Worker:_____Phone Number:_____
Address:_____Fax Number:_____

Emergency Contact:_____Phone Number_____

Identifying Information:
Client Name:_____Preferred First Name:_____
Address:_____
Gender:_____Marital Status:_____Age:_____Date of Birth:_____
Parent/Guardian:_____Phone Number:_____

Reason for Referral:_____
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Pertinant History: (history of symptoms; precipitants; abuse; self-injurious behavior; level of functioning)_____
_____
_____
_____
_____
_____

Treatment History: (previous diagnoses outpatient/inpatient treatment; alcohol/substance abuse history; treatment interventions, effects, compliance, outcome)_____

Social History: (employment; school; teacher; IEP/504; education level; military history; legal status)_____

Family History: (family history of mental health/substance abuse; family make up; custody)_____

Current Medications: (names, doses, side effects)_____

Allergies:_____

Diagnosis:
Axis I:_____
Axis II:_____
Axis III:_____
Axis IV:_____
Axis V:_____

Level of Care:_____

Treatment Plan: (treatment goals/objectives)_____