

**- ClearWind Farm Client Profile Form -**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_

**If Child:**

Parent/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Parent/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
School Name \_\_\_\_\_ Teacher Who Knows Client \_\_\_\_\_

**In Case of Emergency notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Other Telephone \_\_\_\_\_

**Billing Information**

Person Responsible for Bill: \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Employer & Address \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Insurance Information**

Insurance Company \_\_\_\_\_  
Address/City/State/Zip \_\_\_\_\_  
Policy Id.# \_\_\_\_\_ Group Number \_\_\_\_\_  
Secondary Insurance Company (if applicable) \_\_\_\_\_  
Address/City/State/Zip \_\_\_\_\_  
Policy Id.# \_\_\_\_\_ Group Number \_\_\_\_\_

**Primary Care Physician**

Physician \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**How did you hear about our practice?** \_\_\_\_\_

What has drawn you to equine assisted psychotherapy?

If our time together is helpful to you, how would you know it? What would be different?

We will work closely with your in-office therapist. Is there anything you'd like us to know about your treatment with him/her?

Please list key people in your life, identifying with whom you feel the closest, and the most challenged by.

Please list situations or areas of your life (ie. work, driving, being alone) that are most challenging to you these days:

Is there anything else you would like us to know about you and/or your situation?

Do you (or your child) have any medical conditions or physical limitations you would like us to know about?

**What medications (if any) are you (or your child) currently taking?**

<i>Medication</i>	<i>Dosage/day</i>	<i>What does it do for you?</i>	<i>Doctor</i>	<i>How long have you been taking it?</i>

**Symptoms Checklist**

Which of the following symptoms are troubling you (or your child) now?

- eating/weight concerns
- too much sleep
- difficulty concentrating
- getting angry too much
- physical/health problems: \_\_\_\_\_
- paying bills; financial issues
- suspiciousness of others
- tired a lot
- a traumatic experience that lingers in your mind
- difficulty making decisions
- thoughts of suicide or self-injury
- feeling unreal or out of body
- children
- guilt
- nothing is fun
- trouble paying attention
- stomach problems
- drastic changes in mood (top of the mountain to down in the dumps)
- dizzy or lightheaded
- sexual problems
- something else: \_\_\_\_\_
- tearfulness
- too little sleep
- low motivation
- not getting angry enough
- workplace (or school) stress
- decreased need for sleep
- fears that disrupt your life
- racing thoughts
- parents
- shyness
- chest pains
- quick to feel irritated about little things
- hearing or seeing things that aren't there
- restlessness/on edge
- alcohol and/or drug use
- rapid heart rate
- feelings of worthlessness
- difficulty saying "no" to people
- thoughts of hurting someone else
- memory problems
- spouse/partner
- spending sprees
- panicky feelings