EQUUSOMA
EQUINE-ASSISTED TRAUMA RECOVERY

Client Intake Questionnaire

Client Name: _____

Please describe your main reason(s) for seeking services at this time?_____

_____

_____

_____

CURRENT RELATIONSHIP STATUS

☐ Single ☐ Common Law ☐ Separated ☐ Widowed ☐ Cohabitating
☐ Married ☐ Divorced ☐ Polyamory ☐ Other _____

How is your current relationship (if applicable)?_____

_____

_____

_____

IMMEDIATE FAMILY INFORMATION (please complete all applicable)

Relationship	Name(s)	M/F	Date of Birth	Living with You?
Mother(s)				
Father (s)				
Partner/Spouse				
Children				

SIGNIFICANT OTHERS (brothers, sisters, grandparents, step-relatives, half-relatives, etc. Please specify)

Relationship	Name	M/F	Date of Birth	Living with You?

OTHER FAMILY INFORMATION (parents separated, divorced, remarried, family members who are deceased, other special circumstances):_____

_____

_____

_____

CURRENT ISSUES

Have you struggled with the any of the following issues? Check all that apply.

Issue	Current	Past	Issue	Current	Past
Stress/Trouble coping			Suicidal thoughts		
Sleep problems			Trauma history / symptoms		
Grief			Dissociation		
Depression			Mental confusion		
Anxiety			Eating disorder		
Panic attacks			Addictive behaviors		
Fear/phobias			Alcohol concerns		
Interpersonal problems			Drug use		
Sexual issues			Self-harm		
Sexuality or gender			Other: (specify)		

Have you ever received a formal diagnosis from a doctor for any of the above or for any other relevant issue? Do you agree with the diagnosis? _____

_____

_____

_____

If so, who made the diagnosis? _____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when: _____

Has a family member ever attempted/completed suicide? ☐ Yes ☐ No

If yes, who: _____

Have you ever engaged deliberately in self-harm behavior(s)? ☐ Yes ☐ No

MEDICATIONS

Are you currently prescribed any medications? ☐ Yes ☐ No

If yes, please list all of your currently prescribed medications below.

Name of Medication	Date Started	Dose (mg)	Purpose	Name of Prescriber

VITAMINS / NATURAL REMEDIES

Are you currently taking any natural remedies or vitamins? ☐ Yes ☐ No

If yes, please list all of them below.

Name of Vitamin/Remedy	Date Started	Dose (mg)	Purpose

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family experienced difficulties with the following? (Check any that apply and list family member, e.g., spouse, sibling, parent, uncle, grandparent, etc.):

Difficulty	Experienced	Family Member(s) Affected
Depression	☐ Yes ☐ No	
Bipolar Disorder	☐ Yes ☐ No	
Anxiety Disorders	☐ Yes ☐ No	
Panic Attacks	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Alcohol/Substance Abuse	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Learning Disabilities	☐ Yes ☐ No	
Trauma History	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	
Other (specify):	☐ Yes ☐ No	

PSYCHOTHERAPY/TREATMENT HISTORY

Do you currently have an individual therapist, psychiatrist, or any other person helping you with mental or emotional health concerns? ☐ Yes ☐ No

Have you ever received psychotherapy/psychiatric treatment? ☐ Yes ☐ No
Have you ever received alcohol or drug use treatment? ☐ Yes ☐ No
Have you ever been hospitalized for mental health issues? ☐ Yes ☐ No

If yes to receiving any of the above services, as best as you can, please list **current and past** providers in the table below.

PSYCHOTHERAPY/PSYCHIATRIC TREATMENT			
Name of Provider/Treatment Program	Current Primary Provider?	Date Started/Ended Treatment	Response to Overall Experience
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
ALCOHOL OR DRUG USE TREATMENT			
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
PSYCHIATRIC HOSPITALIZATION			
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor
	☐Yes ☐No		☐Good ☐Fair ☐Poor

EDUCATION

	Completed	Partial	
Elementary	☐	Grade ____	
High School / GED	☐	Grade ____	
College/University	☐	☐	Program/Degree _____ / _____
Graduate School	☐	☐	Program/Degree _____ / _____

Other Training_____

Special Circumstances (learning disabilities, gifted, etc.):_____

_____

EMPLOYMENT

Are you currently employed? ☐ No ☐ Yes

If yes, who is your current employer/position?_____

If yes, are you happy at your current position?_____

ALCOHOL/SUBSTANCE USE

What is your average number of alcoholic drinks you have in a week? _____

Do you use any substances/drugs recreationally? _____

If so, please name which substances:_____

SLEEP HABITS

Are you having any problems with your sleep? ☐ Yes ☐ No

If yes, check where applicable:

☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams

☐ Other _____

PHYSICAL HEALTH

How is your overall physical health at present? (please check one)

☐ Very good ☐ Good ☐ Okay ☐ Poor ☐ Bad

Issue	Current	Past	Issue	Current	Past
Muscle / bone injuries			Varicose veins		
Accidents / falls			Heart / circulatory problems		
Sprain / strain			High / low blood pressure		
Arthritis / tendonitis			Allergies		
Abdominal / digestive issues			Blood clots		
Numbness / tingling			Infectious disease		
Sinus congestion			Cancer / tumors		
Pregnancy			Dental / jaw problems		
Surgeries			Immune system issues		
Scar tissue			Thyroid issues		
Asthma / lung conditions			Uro-gynecological / pelvic issues		
Chronic pain			Chronic fatigue		
Fibromyalgia			Diabetes		
Muscle aches / pain			Headaches / migraines		

If comfortable, please provide additional details about the boxes checked in the table above:

_____

_____

_____

_____

_____

_____

EXERCISE

What do you engage in for exercise? _____

How often do you exercise? _____

SPIRITUALITY / RELIGION

How important to you are spiritual matters?

☐ Not at all ☐ Little ☐ Moderate ☐ Very much

How important to you are religious matters?

☐ Not at all ☐ Little ☐ Moderate ☐ Very much

LEISURE / RECREATIONAL ACTIVITIES

Describe special areas of interest or hobbies (e.g., art, books, writing, crafts, physical fitness, sports, outdoor activities, spiritual activities, walking, exercising, diet/health, meditation, yoga, traveling, etc.)

Activity	How Often Now?	How Often in the Past?

What do you consider to be your strengths? _____

_____

_____

_____

_____

_____

What are effective coping strategies that you currently use? _____

_____

_____

_____

_____

_____

Describe your support network (friends, family, community supports)?

When were things better for you? What was different then?

What are your goals for treatment?

On a scale of 0 to 10 (where 10 means things are going well and 0 means the opposite), please circle where you are today on this scale:

0 1 2 3 4 5 6 7 8 9 10

Any additional information that would assist me in understanding your concerns or problems:

What do I need to know about you to work successfully with you?

Client Signature:

Date Form Completed:

Many thanks! We look forward to supporting you in service of your goals.