EAP Client Information Form

General Information

Date:_____

Name: _____ Date of Birth: _____ Age: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Best number and time to reach you directly: _____
Can I leave a message at either or both of these numbers?_____
Email:_____

Emergency Contact:
Name:_____ Relationship:_____ Phone #:_____
I give my permission for this person to be contacted in case of emergency. Initial:_____

Goals for EAP

What is the main reason for you are seeking Equine Assisted Psychotherapy (EAP): _____
_____
_____

What are your goals for EAP? What are you looking to gain from your EAP experience? : _____
_____
_____

Mental & Emotional Health

Indicate the severity of your difficulties on the scale below:
☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe ☐ Incapacitating

Current signs/symptoms (Please check all that apply):

☐ Depressed Mood
☐ More/less sleep than normal
☐ Poor concentration
☐ Increase/decrease in appetite
☐ Decreased energy
☐ Decreased motivation
☐ Increased/decreased sexual desire
☐ Compulsive behaviors (specify):
  - ☐ Gambling
  - ☐ Drugs
  - ☐ Alcohol
  - ☐ Spending/Shopping
  - ☐ Sex
  - ☐ Food
  - ☐ Other_____

☐ Anxiety
☐ Anger/rage
☐ Feel overwhelmed
☐ Food issues
☐ Body image issues
☐ Feelings of hopelessness
☐ Negative view of self
☐ Other_____

Please indicate the major stressors in your life in the last twelve months:

☐ Serious injury/illness ☐ Death of a close friend or relative ☐ Major illness in family

☐ Divorce/Separation ☐ Job Change ☐ Gain of a new family member

☐ Other (please describe):_____

Have you ever thought about suicide? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No If yes, when? _____

Family History:

1. List five words to describe the following:

   Your Mother: _____ Your Father: _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____

   Your parent's relationship with each other: _____
   _____
   _____
   _____
   _____

   What it was like in your house growing up (i.e. chaotic, quiet, fun, etc.): _____
   _____
   _____
   _____
   _____

2. Were/Are your parents: ☐ Divorced ☐ Never Married ☐ Still Married ☐ Widowed

3. Do you have a family history of any of the following? *Please note how the person is related to you.*

☐ Depression _____ ☐ Violence _____

☐ Suicide Attempts_____ ☐ Sexual Abuse _____

☐ Anxiety _____ ☐ Emotional Abuse _____

☐ Eating Disorders _____ ☐ Alcoholism / Drug Addiction _____

☐ Mental Illness _____ ☐ Sexual Addiction _____

☐ Chronic Illness (please explain): _____

☐ Other: _____

Abuse History

☐ I was not abused in any way. ☐ I was abused. If you were abused, please indicate the following:

Your age?	Kind of abuse?	By whom?	Whom did you tell?	Consequences of telling?

Chemical Use

1. Have you ever felt the need to cut down on your drinking/substance use? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticism of your drinking/substance use? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking/substance use? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener"? ☐ No ☐ Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average? _____
6. How much tobacco do you smoke or chew each week? _____
7. Which drugs (not medications prescribed for you) have you used in the last 10 years?

   _____

   Please provide details about your use of these drugs or other chemicals, such as amounts and how often you used them:_____

   _____
8. Have you ever been in a residential treatment program? ☐ No ☐ Yes
   If yes, when, where and for what?_____

Other

Is there anything else that is important for me to know about you?

_____

_____

_____

Client Signature **Date**

Parent/Guardian Signature **Date**

Therapist Signature **Date**