Equine Assisted Therapy & Learning

Client Counseling & Medical History

Client's Name: _____Age: _____DOB:_____

Gender: M or F Height:_____ Weight:_____

Parent/Guardian (if minor): _____Phone: Home & Cell_____

Address:_____City:_____State:_____Zip:_____

Physician:_____Phone:_____

Emergency Contact:_____Phone: Home & Cell_____

Are you currently attending counseling? ___Yes ___No If yes, How often do you see your counselor? _____Name of Counselor:_____Phone_____

Purpose of coming to Counseling and/or Goals of Counseling

_____

_____

Current Medications:_____

Special Precautions/Needs (i.e. Medical, Allergies, Asthma, Impairments in Movement) _____

_____

_____

I give permission for my child/children or myself to be taken to the hospital for treatment in the event of an emergency _____Yes _____No

_____ _____
Signature of Participant Date

_____ _____
Signature of Parent/ Guardian (if under 18) Date