WINDSTONE COUNSELING
Healing with Horses

P.O. Box 5
Springville, UT 84663
(385) 325-0533
www.windstonecounseling.com

Adult Information Form

Client Information

Client Name: _____ Intake Date: _____

Date of Birth: _____ Gender: _____

Mailing Address Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Religious Affiliation: _____

Occupation: _____ Military Experience: _____

Marital Status: _____ Highest Level of Education: _____

If client is a minor, parent/guardian name(s): _____

Parent cell phone number(s): _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Referral

How did you hear about us? _____

Presenting Problem and Current Symptoms

Briefly describe the reason you made today's appointment and when the problem began:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Mental Health History

Have you ever received a mental health diagnosis in the past?: Yes No (if yes please list below)

Diagnosis	**By Whom**	**When**

Have you previously received psychotherapy services? Yes No (If yes please list below)

Provider	**Reason**	**When**

Have you been admitted to a psychiatric unit/hospital/residential facility? Yes No (If yes please list)

Where	**Reason**	**When**

Have you ever attempted suicide? Yes No (If yes please explain details, # of attempts & method)

Trauma

Do you have a history of emotional abuse? Yes No
Do you have a history of physical abuse? Yes No
Do you have a history sexual abuse / assault? Yes No
Do you have a history of childhood neglect? Yes No

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If you answered yes to any form of abuse or have experienced any trauma please explain below:

_____

_____

_____

Medical History

Who is your primary medical provider?

Name _____ Phone _____ Address _____

Do you have any current or past major medical concerns? Yes No (If yes please explain below)

_____

_____

Are you currently taking any medications? Yes No (If yes please list below)

Medication	**Purpose**	**Dose**	**Start Date**

Prescriber's Name: _____ Prescriber's Phone Number:_____

Substance Use

Please list all substances(s) you currently use (i.e., cigarettes, alcohol, drugs):

Name	**Amount/ frequency**	**Start Date**

Legal History

Have you ever been involved with the legal system? Yes No (If yes please explain below)

_____

_____

_____