Confidential Client Information

(To be completed by the therapist in collaboration with the client)

This information is confidential. If you have any concerns about the relevance of any information, please let me know.

Your name:……..

Address:……..

……..

Post Code:……

Home phone:……..

Mobile number:……

E-mail address:……

Is it ok to leave a message on any of these numbers? Yes No

Please specify your preferred number or email address for us to contact you on:

Age:…… Birth date: ……..

Current Occupation:……

Person to alert in the event of medical emergency:……..

Relationship to you: ……Phone:……..

Family Doctor: …… Phone:……..

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Spouse/partner's 1st name:……..

Yrs in relationship:……

How is your current relationship?

Children (gender, age, relationship quality, contact):

Family of origin:
Mother- name, age, relationship/ contact:

Father- name, age, relationship/ contact:

Significant others- name, age, relationship/ contact- (siblings/ grandparents/ step relatives/ half relatives/ aunts/ uncles):

Other family information (parents separated, remarried, deceased, adopted, fostered etc.):

Significant Personal history:

Safe place/people growing up:

Safe place/ people now- support network (animals, friends, hobbies, sport etc.):

What are your personal strengths?

How is your overall physical health at the moment? Are you sleeping, able to eat etc.

Do you have any medical problems? If yes, what are they:

Please describe your mental health history; do you have a history of depression, anxiety or any psychiatric treatment? If yes, please describe:

Have you struggled with any of these issues? (please circle relevant issues)

	Y/N		Y/N
Stress/ trouble coping		Panic attacks	
Grief		Suicidal Ideation	
Depression		Anxiety	
Addiction: (circle) food/ drugs/ alcohol/ sex/ work/ shopping/ other		Self-harm	
Flash backs		Dissociation	
Nightmares		Black outs	
Eating issues; bulimia/ anorexia		Suicide attempts	
Loneliness		Overwhelm/ despair	
Unable to sleep		Always want to sleep	

Have you ever been hospitalized for a psychological difficulty? Yes No

If yes, please give the dates and the nature of the difficulty at the time:

Have you ever attempted suicide? Yes No

If yes, please give the dates and the number of attempts:

Have you ever had a family member attempt suicide or die by suicide? Yes No

If yes, please give details about who it was and when it happened.

Have you ever used self-harm as a way to cope? Yes No

If yes, when and do you still self harm?

Are you on any medication? If yes, what drug and what dose, what is the drugs purpose:

Are you seeing any other therapist, psychologist or psychiatrist? Yes No
If yes, please give the name of the clinician(s) and their contact details.

Have you ever had any traumatic or really difficult experiences?

Do you use drugs or alcohol? Which ones and how frequently:

Do you have any experience with horses, if yes please write down your experience? Was your experience with horses positive or negative?

What do you hope to get out of our sessions together?