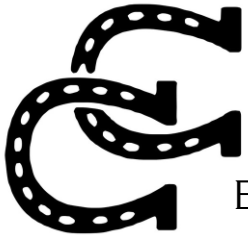

Compassion Corral

Equine Facilitated Counseling
469-833-8236
Compassioncorral.com

Real-Genuine-Hope

Adult Intake

Name:_____ Birth date:_____ Age:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell:_____ Work:_____

May we call you and leave messages at home? _____Yes _____No

May we call you and leave messages on your cell? _____Yes _____No

May we send mail to you at this address? _____Yes _____No

Insurance Information (Note: Compassion Corral only files if your provider is contracted with your insurance plan. Complete only if we are filing claims for you.)

Ins. Company_____ Phone:_____

Subscriber's Name:_____ Relationship to client:_____

Employer:_____ Birth date:_____

Member ID:_____ Group Number:_____

May I thank someone for referring you? _____

What is your religious affiliation? _____

Education/Degrees: _____

Occupation: _____ How Long:_____

Place of Employment: _____ How Long: _____

If not employed, how long has it been since you worked? _____

Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed

___Living Together

Current and Past Marriages or Significant Relationships

To Whom Length of Relationship Children from Relationship (if any)

_____

_____

_____

_____

If married, separated or living together, briefly describe your relationship:_____

_____

_____

_____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs	How do you get along?

Is it: satisfactory? _____ Unsatisfactory? _____

Would it be beneficial for any member(s) of your family to be involved in your therapy? If yes, please explain:_____

_____

_____

_____

Briefly describe what it was like growing up in your family. _____

_____

_____

_____

_____

Family History/Risk Factors

	Children	Siblings	Mother	Father	Grandparents	Aunts	Uncles	Others
Depression/Suicide								
Psychiatric Treatment								
Drinking Problems								
Drug Abuse								
Physical Abuse								
Sexual Abuse								
Emotional Abuse/Neglect								
Other Traumatic Event								
Eating Disorder								

Medical Information

When were you last examined by a physician? _____

Name of Doctor:_____

Are you currently taking any medication(s)? _____Yes _____No

Supplements? _____Yes _____No

Name of Medication	Dosage/Frequency	Prescribing Physician

Psychological Information

Have you ever sought help or been treated for psychological or emotional reasons?

_____

If so, when and where? _____

What was the outcome? _____

Have you ever had any previous treatment for drug/alcohol abuse? _____

_____

Is this an area of concern for you? _____

Spirituality

I describe myself as: (- indicates liability, + indicates strength)

( )Perceives life as fulfilling ( )Believes life has meaning ( )Shares life with others

( )Has sense of community ( )Experiences appreciation/ respect

( ) Feels faith is growing ( )Feels listened to by others

( )Experiences presence of "God"

I believe my sense of community is:

( )Full; surrounded by supportive people ( )Adequate; feels some support

( )Inadequate; support system doesn't meet needs ( )Absent; client feels alone

Circle any problem/symptom that pertains to you at the present time:

Anger	Education	Sexual Issues	Work	Drug Use
Loneliness	Marriage	Fatigue	Ambition	Stomach Problems
Divorce	Finances	Appearance	Age	Suicidal Thoughts
Future	Friends	Concentration	Nightmares	Temper
Parenthood	Health Problems	Nervousness	Relaxation	Making decisions
Stress	Self-Esteem	Sexual Orientation	Anxiety	Physical Abuse
Children	Career Choices	weight	Shyness	Sexual Orientation
Fears	Legal Matters	Self Control	Headaches	Under/Overeating
Memory	Sleep Issues	Change in Appetite	Depression	Alcohol Use
Unhappiness	Mood Swings	Worry/Panic		

Other:_____

Suicidal/Homicidal Ideation

Have you attempted suicide or homicide in the past? _____

Is there a history of suicide in your nuclear or extended family? _____

Are you presently suicidal or homicidal? _____

Have you ever used non-suicidal self-harm to reduce stress or cope? _____

Circle everything that you have experienced in the past three years:

Death of a Spouse/Partner	Marriage Problems	Changes in Marital Status
Death of a Family Member	Family Problems	Loss of Job
Major Illness or Injury (Self)	Financial Problems	Legal Problems
Major Illness or Injury (Family)	Move to Another City or State	

Nutrition

Do you feel you have balanced, healthy eating patterns? _____

Do you have a lot of concerns about your weight and shape? _____

Do you often eat out of depression, boredom or anger? _____

Do you ever binge eat or fear losing control of your eating? _____

Do you ever self-induce vomiting? _____

How do you feel about eating with others in a group? _____

Do you use laxatives, diuretics, or diet medications to control your weight? _____

Do you or others believe you exercise excessively? _____

Social Relationships/Support System

Who can you count on for support? Check as many as apply.

____parents ____Spouse ____Siblings ____Extended Family ____Employer ____Church

____Pastor ____Doctor ____Neighbor ____Co-Worker ____Close Friend

What are your hobbies or leisure activities? _____

Did you have any unusual or traumatic experiences as a child?

Date	Age	Event

What are your Goals for Therapy? _____

_____

Please list any additional information you would like me to have:_____

_____

What is the best way for me to contact you if necessary? _____

_____

Emergency Contact (should an emergency occur while you are on our premises, you give consent for us to contact this person). _____

_____