
# Hillside HOPE Thru Hooves

Equine Assisted Mentoring
763-238-7283

## CLIENT INFORMATION

Name: _____DOB:_____

Home Phone:_____ Cell _____Wk:_____

Address:_____

City:_____State_____Zip_____

E-Mail: _____

Emergency Contact and Phone: _____

How did you hear about us? _____

Are you under a doctor's care? _____ Medications taking & what for?

_____

Are there any physical limitations or problems that we should be aware of?

_____

Court Referral Info:_____

_____

Probation officer Name & Number: _____

History of drug abuse: _____

List Previous Counseling and Treatment Programs: _____

_____

Please briefly describe the problem(s)or situation you would like help with:

(Please Check all that apply) I am or have struggled with:

___Abuse ___Abortion ___Adoption ___Anger ___Anxiety ___Addictions

___Cutting ___Depression ___Fear ___Isolation ___Loss ___Panic Attacks

___Rejection/Abandonment ___Self-Esteem Issues ___Shame ___Other:_____