Sky Riding LI

Classical Riding · EFP · Therapeutic Riding

Mental Health Data form

Client's Name: _____

Age: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

Parent/Legal Guardian: _____ Phone: H _____ W _____

Address: _____

Physician: _____ Phone: _____

Mental Health Professional: _____ Phone: _____

Diagnosis (DSM - IV)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Presenting Problems

_____

_____

_____

_____

_____

Current Medications

Drug	Dose	Route	Time	Purpose

Psychiatric Treatment History

Current Therapy	Where	When	Diagnosis
Outpatient Therapy			
Inpatient Therapy			