Referral Form

Healing Hoof Steps

Client Name _____ Age:_____ D.O.B:_____ SS#_____ ____ _____ M / F

Address:_____ _ City & State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____ Message OK? Y / N

Caller Name:_____ Phone#_____Email: _____Relationship to Client:_____

Legal Guardian: (must sign all paperwork)

Legal Guardian phone numbers: H_____ C_____ Email:_____

Referring Organization/Contact Person: _____ Phone: _____ Email: _____

Reasons seeking therapy: _____

Previous Treatment?_____Provider: _____

_____

Existing Diagnoses? _____

Psychiatric Hospitalization in past year? _____

Legal Involvement:_____ On probation? Y / N

Medications: _____

Prescribed by:_____ Current Therapist:_____

Medical Issues we should know about: _____

Who will provide transportation? _____

Please Mark Funding: [ ] Self-Pay/Private Ins. (payment due at session) [ ] Medicaid [ ] Grant [ ] Scholarship Fund (waiting list)

Service Type(Select All That Apply) [ ]Equine Assisted Psychotherapy [ ] Accelerated Resolution Therapy [ ] Alpha-Stim
[ ]Therapeutic Riding [ ] Traditional Talk therapy [ ] Group Therapy [ ] Couples Therapy

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For Office Use Only

If Phone Screening: Answered by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____

If Outside Referral: Fax Received by:_____ Date:_____

Client Contacted for Intake by:_____ Date:_____