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## ADULT EQUINE THERAPY INTAKE FORM

### GENERAL INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your age: \_\_\_\_\_ Date of Birth (DOB): \_\_\_\_\_

Address: \_\_\_\_\_

Spouse or Partner's Name (if applicable): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

Home phone: \_\_\_\_\_ May I leave a message? Yes No

Cell phone: \_\_\_\_\_ May I leave a message? Yes No

May I leave a *text* message? Yes No

Work phone: \_\_\_\_\_ May I leave a message? Yes No

Email: \_\_\_\_\_ May I email you? Yes No

Referred by: \_\_\_\_\_

What is the main reason you're seeking help? \_\_\_\_\_

How long has this been an issue? \_\_\_\_\_

What are your goals for equine therapy? \_\_\_\_\_

### MENTAL HEALTH INFORMATION

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

Have you ever been hospitalized for mental illness? If so, list when, where, & reason:

Have you ever experienced any situation that you would consider traumatic for you?

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When you were a child, did you struggle with any of the following:

			<u>Age</u>
Learning disabilities	Yes	No	_____
Hyperactivity	Yes	No	_____
Bed wetting	Yes	No	_____
School fears	Yes	No	_____
Teasing/Bullying	Yes	No	_____
Eating disorders	Yes	No	_____
Witnessing violence in the home	Yes	No	_____
Sexual, physical or emotional abuse	Yes	No	_____

If so, by whom? \_\_\_\_\_

### **FAMILY PSYCHIATRIC HISTORY**

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

### **MEDICAL CONDITIONS & HISTORY**

Do you currently have any medical problems? \_\_\_\_\_

Have you ever been hospitalized for medical reasons? If so, list when, where and reason:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any unexplained aches, pains, nerve or joint pain?  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated for any of the following? If so please circle and describe:  
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

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How many times a week do you exercise? \_\_\_\_\_ What type and how many minutes? \_\_\_\_\_

How would you describe your diet? \_\_\_\_\_

Do you have any concerns about your overall health? (If so, please describe)

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### **MEDICATIONS & PHYSICIAN INFORMATION**

Please list current prescription medications with dosage (psychiatric and general health):

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Please list any previous psychiatric medications (with dosage and dates): \_\_\_\_\_

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Who is your primary care physician? \_\_\_\_\_

Who is your psychiatrist (if applicable)? \_\_\_\_\_

When was your last complete physical exam (month/year)? \_\_\_\_\_

### **SUBSTANCE USE**

Do you drink alcohol or use recreational drugs? If so, what kind and how often? \_\_\_\_\_

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Do you or anyone close to you consider your use to be a problem?    Yes    No

### **FAMILY INFORMATION (Family of Origin)**

Where were you born? \_\_\_\_\_

Where did you live most of your childhood? \_\_\_\_\_

	MOTHER	FATHER
<b>Current age, or if deceased date, age, and cause of death.</b>		
<b>Country of Origin</b>		
<b>Religious/Spiritual Affiliation (if any)</b>		
<b>Use 3 adjectives or more to describe <u>each</u> parent.</b>		
<b>How did you and <u>each</u> parent get along when you were growing up?</b> Give some examples of things that you did together & feelings you had.		
<b>Use 3 adjectives or more to describe your parents' relationship.</b>		
<b>How did your parents get along?</b> What were any things they disagreed over?		
<b>Years married/together (parents)</b>		
<b>If divorced or not together, your age at divorce.</b>		
<b>Reason for divorce/split</b>		
<b>Describe your relationship with step-parents (if any).</b>		
<b>List anyone else who lived with you <u>or</u> regularly cared for you.</b>		
<b>Were you adopted? Age?</b>	<b>If so, please write any relevant information about your biological parents.</b>	
<b>List any issues in your family growing up:</b>		

**Siblings**

Please list all of your brothers and sisters in the order of birth (if applicable).

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

**Children**

Please list your biological, adopted or stepchildren (if applicable).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

**INTIMATE RELATIONSHIPS & SOCIAL SUPPORTS**

Are you currently married? Yes No How long? \_\_\_\_\_

Are you currently partnered/in a romantic relationship? Yes No How long? \_\_\_\_\_

Do you have any concerns about your current marital or romantic relationship that you would like to discuss?

If so, what are they? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently separated or divorced? Yes No How long? \_\_\_\_\_

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? To whom can you turn to for emotional and other forms of support?

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**EMPLOYMENT & EDUCATIONAL INFORMATION**

Are you currently employed?      Yes    No                      Are you currently a student?      Yes    No

What was the highest grade of education you completed? \_\_\_\_\_

Please describe your current work or academic situation: \_\_\_\_\_

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Do you enjoy your work/school? Is there anything stressful about it? \_\_\_\_\_

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**INTERESTS/ACTIVITIES/SPIRITUALITY**

What are some of your interests/hobbies & activities? \_\_\_\_\_

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Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :\_\_\_\_\_

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**ADDITIONAL INFORMATION**

Do you have any legal history or current legal problems or concerns you feel I should know about? For example, have you ever been charged with DWI/DUI, dealt with custody battles, legal issues related to crime, etc?

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Have you experienced any unusually severe stresses during the last year?                      Yes    No

If yes, please describe: \_\_\_\_\_

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What do you consider to be your strengths? \_\_\_\_\_

What do you consider to be your areas of needed growth? \_\_\_\_\_

Is there any other information you'd like to add?

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How much are each of the following areas currently a problem for you? Please circle.

	<b>Not at all</b>	<b>A little</b>	<b>Somewhat</b>	<b>Considerably</b>	<b>Terribly</b>
	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<u>Anxiety</u>	1	2	3	4	5
<u>Physical Problems</u>	1	2	3	4	5
<u>Sleep Problems</u>	1	2	3	4	5
<u>Depression</u>	1	2	3	4	5
<u>Alcohol or Substance Abuse</u>	1	2	3	4	5
<u>Family Conflicts</u>	1	2	3	4	5
<u>Marital Conflicts</u>	1	2	3	4	5
<u>Social Relationships</u>	1	2	3	4	5
<u>Job/School</u>	1	2	3	4	5
<u>Sexual Problems</u>	1	2	3	4	5
<u>Spiritual/religious</u>	1	2	3	4	5
<u>Legal Problems</u>	1	2	3	4	5
<u>Eating Disorder/Struggles</u>	1	2	3	4	5
<u>Abuse (physical, emotional, sexual)</u>	1	2	3	4	5



## Financial Agreement Form and Privacy Disclosure

Please review the Financial Agreement and Privacy Disclosure:

I agree to:

1. To pay \$155 for the initial assessment and \$145 per 53-minute session thereafter.
2. To pay an hourly rate of \$125 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, and treatment summaries.
3. Payment is expected at the beginning or end of each session, unless prior arrangements have been made.
4. **Appointments not cancelled 24 hours in advance will be charged a \$75 no-show fee which must be paid before the next session.**
5. A \$25 service charge will be added to all returned checks and must be paid at the next session.
6. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy and does not guarantee that any/all fees will be covered by insurance.
7. **Benefit Check Disclaimer:** While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. This is an estimate as of today, and we won't know your exact fee until we bill your insurance and get your explanation of benefits back from your insurance company. You are also encouraged to call the number on the back of your insurance card and ask your member representative about your 'mental health, outpatient, office visit' benefits. Please let me know if you have any questions about your benefits.
8. Explanation of any alternate payment plan:

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### INSURANCE INFORMATION

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Phone Number: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

**I understand the above payment procedures and I agree to this plan of payment.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**I give Clearhope Counseling Center permission to bill my insurance as indicated above.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**I have received a copy and reviewed the Clearhope Counseling Center Privacy Disclosure: Your Information. Your Rights. Our Responsibilities.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_





**PRIVACY DISCLOSURE: YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

<b>YOUR RIGHTS</b>	<b>YOUR CHOICES</b>	<b>OUR USES AND DISCLOSURES</b>
<p><b>Your have the right to:</b></p> <ul style="list-style-type: none"> <li>• Get a copy of your paper or electronic medical record</li> <li>• Correct your paper or electronic medical record</li> <li>• Request confidential communication</li> <li>• Ask us to limit the information we share</li> <li>• Get a list of those with whom we’ve shared your information</li> <li>• Get a copy of this privacy notice</li> <li>• Choose someone to act for you</li> <li>• File a complaint if you believe your privacy rights have been violated</li> </ul>	<p>You have some choices in the way that we use and share information as we:</p> <ul style="list-style-type: none"> <li>• Tell family and friends about your condition</li> <li>• Provide disaster relief</li> <li>• Include you in a hospital directory</li> <li>• Provide mental health care</li> <li>• Market our services and sell your information</li> <li>• Raise funds</li> </ul>	<p>We may use and share your information as we:</p> <ul style="list-style-type: none"> <li>• Treat you</li> <li>• Run our organization</li> <li>• Bill for your services</li> <li>• Help with public health and safety issues</li> <li>• Do research</li> <li>• Comply with the law</li> <li>• Respond to organ and tissue donation requests</li> <li>• Work with a medical examiner or funeral director</li> <li>• Address workers’ compensation, law enforcement, and other government requests</li> <li>• Respond to lawsuits and legal actions</li> </ul>

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

• **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

• **Run our organization**

We can use and share your health information to run Clearhope Counseling Center, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

• **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues** We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research** We can use or share your information for health research.

**Comply with the law** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

**Respond to organ and tissue donation requests** We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

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- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).