Website: www.mccaskillfamilyservices.com
E-mail: office@mccaskillfamilyservices.com
Fax: 734-416-0158

Plymouth Location:
409 Plymouth Rd., Suite 250, Plymouth, MI 48170
734-416-9098
Brighton Location:
2040 Grand River Annex, Suite 300, Brighton, MI 48114
810-224-1676

EQUINE THERAPY QUESTIONNAIRE

Name of Participant:	**Date of Birth:**	**Age:**	**Gender:**
School or Place of Employment	**Grade (if applic)** ***If summer, grade just completed.***		
Home Address Number and Street	**City**		**Zip Code**
Person completing this form and relationship to participant:	**Date form completed:**		
Pediatrician/Physician:	**Who referred you MFS Equine Therapy?**		
Emergency Contact Name:	**Emergency Contact Phone Number:**		

If necessary, I give McCaskill Family Services permission to call me at the following phone numbers:

Name/Relationship to Participant	Work Number	Ok to leave message?	Cell Number	Ok to leave message?	Home Number	Ok to leave message?
		Y N		Y N		Y N
		Y N		Y N		Y N
		Y N		Y N		Y N
		Y N		Y N		Y N

List all people living in household:

Name	Relationship to Participant	Age

Primary language spoken in the home:	Other languages spoken in the home:
Name of person responsible for bill:	SS#

Are you or your child involved in any legal issues at this time (i.e., probation, divorce, custody issues, etc.): Yes No

Have you or your child ever been in trouble with the law? Yes No

If yes, please tell us more:

Presenting Problem

Place a check next to any areas that you (your child) is currently experiencing difficulties with or for which you have concerns:

	Speech & language		Specific fears or phobias
	Coordination		Tics or repetitive behaviors
	Toileting accidents		Rigid/repetitive rituals or routines
	Stubborn/strong-willed behavior		Prefers to be alone
	Aggression		Bites nails or has other nervous habits
	Impulsive behavior		Easily stressed/anxious
	Bangs head/hurts self		Does not get along with siblings/family members
	Is too active (e.g., trouble sitting still, high energy)		Does not get along well with friends/peers
	Excessive video game playing/technology use		Making and/or keeping friends
	Following directions		Is shy or timid
	Attention/focus		Is more interested in things than in people
	Motivation levels		Recognition of social cues
	Behavior that is dangerous to self or others		Blank staring spells
	Tantrums/Meltdowns Frequency: Intensity:		Eating habits (e.g., excessive/restricted eating, picky eater, nutritional imbalance)
	Homework/study habits		Frequent nightmares
	Problems at work		Marital/relationship problems
	Grades		Sleep
	Problems with coordination/balance		
	Fire-setting		Running Away
	Grief/Loss		Eating Disorder/problems
	Depression		Anxiety

Have your (or your child) ever participated in a psychoeducational, neuropsychological or other evaluation for learning, emotional, or behavioral concerns? Please list evaluation history below:

Evaluator/Clinic Name	Date(s) of Evaluation	Findings and/or Diagnoses Received

Have you or your child ever participated in therapy for treatment of emotional, behavioral or other mental health concerns? Please list history below:

Therapist/Clinic Name	Dates of Treatment	Findings or Diagnoses Received

Medical History:

Medical providers:

Current physician:	How long have you (your child) been seen by this provider?
Phone #:	Fax #:

Address:

Allergies:

Allergy	Reaction

Current Medications:

Name of Medication	Prescribed by	Date your child began medication	Current dosage & date dosage was started	Previous dosage(s) & date dosage(s) prescribed

History of illness/medical conditions:

Place a check next to any illness or condition that you (your child) has had. When you check an item, also note the date(s) or age(s) when illness or condition was diagnosed/experienced.

Check	Illness or Condition	Date(s)/Age(s)
	Measles	
	German measles	
	Mumps	
	Chicken Pox	
	Whooping cough	
	Extreme tiredness	
	Weakness	
	Growth delays	
	Diphtheria	
	Scarlet fever	
	Rheumatic fever	
	Meningitis	
	Epilepsy	
	Tuberculosis	
	Bone or joint disease	
	Gonorrhea or syphilis	
	Anemia	
	Jaundice/hepatitis	
	Diabetes	
	Cancer	
	High blood pressure	
	Heart disease	
	Other:	

Check	Illness or Condition	Date(s)/Age(s)
	Asthma	
	Bleeding Problems	
	Visual Problems	
	Hearing Problems	
	Frequent/Severe Headaches	
	Dizziness/Fainting	
	Eczema or Hives	
	Suicide attempt	
	Hospitalization related to suicidal thoughts/behaviors	
	Memory problems	
	Paralysis	
	Loss of consciousness	
	Concussion	
	Encephalitis	
	High fever	
	Convulsions/seizures	
	Hay fever	
	Head injuries	
	Broken bones	
	Hospitalizations	
	Operations	
	Ear problems	
	Other:	

Family Medical History:

Place a check next to any illness or condition that any member of the participants family has had (or suspected). When you check an item, please note the member's relationship to the participant.

Check	Condition	Relationship to child
	Alcoholism	
	Cancer	
	Diabetes	
	Heart trouble	
	Genetic Disorders	
	Bipolar Disorder	
	Anxiety Disorder	

Check	Condition	Relationship to child
	Depression	
	Learning disability Specify type:	
	ADHD	
	Cognitive impairment	
	Developmental delay	
	Autism	
	Other:	

Additional Participant Questions:

Have you ever engaged in aggression toward animals? Yes No
If yes, explain _____

Have you ever engaged in physical aggression with others? Yes No
If yes, explain _____

Are you currently using any illicit drugs or alcohol on a daily basis? Yes No
If yes, please indicate type and amount per day _____

Have you ever received treatment for drug or alcohol addiction? Yes No
If yes, please provide type of treatment and dates _____

Do you smoke cigarettes? Yes No
If yes, are you comfortable not smoking for the time you are at the barn? _____

Do you currently have thoughts to hurt yourself or someone else?
If yes, please explain _____

What are your current methods of coping with uncomfortable feelings?
_____
_____
_____

What do you feel are your current strengths?
_____
_____
_____

What do you feel you need to work on, or need help with, the most?
_____
_____
_____

Do you have any horse experience? Yes No
If yes, please tell us more: _____

On a scale of 1-10, rate your fear of horses (1 – none, 10 = high) : _____
If answered any number above a 1, what specifically scares you about them?
_____

Do you have any physical limitations that would prevent you from walking, standing, and/or being in the sun for 90 minutes? Yes No

Do you have a history of seizures? Yes No
If yes, when was your last seizure: _____

What are your (your child's) hobbies/interests?

_____
_____
_____

I think it would be helpful for my equine clinician/therapist to contact the following professionals who also participate or have participated in my (my child's) care (e.g., physicians, therapists, etc.).

Professional's Name & Profession	Phone Number	Fax Number	E-mail Address	Mailing Address

****Please see clinician/therapist to sign an authorization form so that he/she may contact the professionals cited above.**

Please use this space (or attach additional pages) for any other information that would be helpful for us to know when working with you or your child. Thank you.

My signature below indicates that the information contained in this document is true to the best of my knowledge.

Name: _____ Relationship to Participant: _____

Signature: _____ Date: _____