



### Therapeutic Riding Interest Form

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

**Client Information:**

Name: \_\_\_\_\_

Age: \_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight **REQUIRED:** \_\_\_\_\_ (180lbs - current max # for riding) Parent/

Legal Guardian 1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Legal Guardian 2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Contact Number: \_\_\_\_\_ Email: \_\_\_\_\_

**How do you see Equine Assisted/Animal Assisted Services being useful?**

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**Which County are you in:**

Dodge      Fond Du Lac      Washington      Waukesha      Milwaukee      Ozaukee

**Are you part of any programs:** Children's Long-Term Services (CLTS)      IRIS (iLife or Premier)

**Program Interests:**

Therapeutic Riding (TR)

Stable Moments (SM)

**Availability ~ Circle ALL that apply:**

AM hours: \_\_\_\_\_ PM hours: \_\_\_\_\_ Monday      Tuesday      Wednesday      Thursday      Friday

**Billing Information**

Billing Agency: \_\_\_\_\_

Billing Agency Address: \_\_\_\_\_

Billing Agency Contact: \_\_\_\_\_

Billing Agency Phone: \_\_\_\_\_ Email: \_\_\_\_\_



**Current Diagnosis:**

Mental Health Related DSM-V

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Medical Related ICD10

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**Any current medications or serious Illness or Allergies to environment, foods, medications etc.?**

No    Yes    please list:

**Will the client be accompanied by a Support person/Behavioral assistant during session?**

No    Yes    List information:

Support/Assistant Name: \_\_\_\_\_

Support/Assitant Phone: \_\_\_\_\_ Email \_\_\_\_\_

Is there any history of client violence directed at people or animals? If yes please explain.