

SunDance Riding Therapy, Inc.
Mental Health Data Form (must be completed annually)



Client Name _____

Date of Birth _____ Current Age _____

Sex _____ Height _____ Weight _____

Parent or Guardian Name _____

Parent/Guardian Address and Phone Number _____

Physician Name and Telephone Number _____

Therapist Name and Telephone Number _____

Diagnosis (DSM-IV)

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

(Continued)

Presenting Problems

Current Medications

Drug	Dose	Route	Time	Purpose

Psychiatric Treatment History

Therapy	Where	When	Diagnosis
Current			
Outpatient			
Inpatient			