HORSE SENSE
of the Carolinas

Client Referral Form

Name:____ Date:_____________________

Age:________DOB:_________________Preferred Pronouns: _______________ Prefer not to answer _____

Address:____

City/State:____Zip Code:_______________________

Phone:___________________________Cell Phone:________________________Voice Mail OK? Y N

Client/Guardian Email:____

Name of Person Referring:____

Relationship to Client:______________________________________Phone:_________________________

Name of Legal Guardian (if client is under 18):____

Phone:____Cell Phone:_______________________________

Best Day/Time for Therapy:____

Reasons seeking therapy:____

Existing Diagnoses:____

Psychiatric Hospitalization in the past year? Y N If yes, where?________________________

Legal Involvement? Y N Are you currently on probation? Y N

Current Therapist:______________________________________Phone:______________________

Medical Issues:____

All Current Medications:____

Demographics:

We occasionally have financial support available based on any current grants we have. Please complete this section so we can identify available funding sources to assist with payment.

Race: _____________________________ Does client identify as LGBTQIA? _______________

Please mark if client is a: ____ Veteran ____ First Responder ____ Police Officer/Law Enforcement

____ FireFighter ____ Health Care Worker ____ Victim of Crime ____ At risk youth ____ Teacher