HIGHHOPES
Horses and Humans Improving Lives™

MENTAL HEALTH DATA FORM

Client's Name: _____ Date: _____

Treatment Coordinator/Therapist: _____ Phone: _____

Presenting Problems

_____
_____
_____
_____

Diagnoses (DSM-V)

Diagnoses:_____
_____ _____
Relevant Psychosocial and/or Contextual Factors: _____
_____

History

_____
_____
_____
_____

Current Medications

Drug	Dose	Route	Time	Purpose

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			

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