truenorth
training stables

Client Personal Data Form and Application

- **Please fill in as much data as possible on this form so we can carefully evaluate your needs and placement into the program. Additionally, please understand that we have limited space, and while it is our greatest hope that we can provide mentoring to everyone, that might not be possible. We will evaluate each applicant's needs and work our hardest to assist each person who applies.**

All CLIENT forms (if client is under age 18) MUST be filled out by parent or guardian.

Parent/Guardian Information

Name_____Phone_____Date_____

Address_____

City_____State_____ Zip Code_____

Cell_____Email_____

Applicant (client) Information (Mandatory)

Name_____Phone_____Date_____

Address_____

City_____State_____ Zip Code_____

Cell_____Email_____

Birthdate_____ Gender Male_____Female_____ Age_____

School Attending_____ Grade_____Years at this school _____

Hobbies_____

_____

Do you have experience with horses or other animals? If yes, please describe briefly._____

_____

Do you currently have a job?_____

How many siblings do you have?_____

Ages of siblings_____

Were you raised by someone other than your parents?_____

Who lives in your house? _____

Health History (Mandatory)

Have you ever had a severe emotional upset? Yes ____ No ____

Have you ever had any psychotherapy or counseling before? Yes ____ No ____

If yes, list the counselor or therapist and dates:_____

_____

What was the outcome?_____

_____

List any fears you have:_____

_____

Place an X after any of the following words that best describe you now:

Active		Ambitious		Self-confident		Persistent		Anxious	
Hardworking		Impatient		Impulsive		Moody		Often sad	
Excitable		Imaginative		Calm		Serious		Easygoing	
Shy		Fearful		Introvert		Extrovert		Likable	
Leader		Quiet		Inflexible		Submissive		Sensitive	
Lonely		Self-conscious		Bitter		Angry			

Approximately how many hours of sleep do you get a night?_____

When do you go to sleep at night?_____ When do you get up?_____

Rate your health: Very Good_____ Good____ Average____ Declining____ Other_____

Your approximate weight:_____ Height:_____

Weight changes recently: Gained:_____ Lost:_____

List all important present and past illnesses, surgeries, injuries, or handicaps: _____

_____

_____

_____

Date of last medical exam:_____What was the report?_____

Name and address of your physician:_____

_____

Are you currently taking any medications? Yes ____ No ____ If yes, please list:

_____

Do you have any allergies? Yes____ No____ If yes, please list:

_____

Have you used drugs for other than medical purposes? Yes ___ No___ What?_____

Basic Questions (Mandatory)

Please briefly answer the following questions:

What is your understanding of the problem or your needs?

_____

_____

_____

_____

_____

What steps have you taken to resolve the problem?

_____

_____

_____

_____

_____

How would you like us to help you with this? (What are your expectations?)

_____

_____

_____

_____

_____

What brings you here at this time?

_____

_____

_____

_____

Can you think of any other information we should know?

_____

_____

_____

Religious Background (Optional)

Denominational preference_____

What church do you attend?_____ City:_____

Approximate number of church services you attend per month: _____

Do you believe in God? Yes____ No____ Uncertain____

Do you pray to God? Yes____ No____ Occasionally____

How much do you read the Bible? Often____ Never____ Occasionally____

Does your family regularly read the Bible and pray together? Yes____ No____

Explain any recent changes in your religious life, if any: _____