Hilltop
Therapeutic Riding Program, Inc.
MENTAL HEALTH DATA FORM

Client's Name: ____

Treatment Coordinator/Therapist: ______________________ Phone: __________

Presenting Problems

____
____
____
____
____
____

Diagnosis (DSM-IVTR)

Axis I ____
Axis II ____
Axis III ____
Axis IV ____
Axis V (GAF) ____

History

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____
____
____
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Current Medications

Drug	Dose	Route	Time	Purpose

Psychiatric Treatment History

	Where	When	Diagnosis
Current Therapy			
Outpatient Therapy			
Inpatient Therapy			

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