

New Client Intake Form

From the Ground up Healing

Horse(s) Name: _____ Age(s): _____

1. Nutrition (what is their everyday meal, supplements, free-choice, etc.):

2. Hoof Trimming Schedule / Hoof-related problems:

3. Last Dental Float / Teeth-related problems:

4. Medical History (any injections, meds, injuries, arthritis, etc.):

5. Horse's Environment (everyday living conditions, routine, do they live alone or in a herd, turnout time, enrichment, etc.):

6. Work / Exercise / Stimulation / Bonding (riding schedule, discipline, liberty, ground work, training routine, playtime, etc.):
