Horse Intake Questionnaire

Owner

Name:_____

Address: _____

Email: _____Phone:_____

Description of Horse:

Registered Name: _____Barn Name: _____

Age: _____Sex: Mare / Gelding / Stud Color: _____

Height (In hands) _____ Breed: _____

Tattoos/Brands/Markings: _____

Preferred Veterinarian: _____Phone: _____
Preferred Farrier and Phone: _____

Last farrier visit: _____ SHOD? Yes/No Front/Back

Last dental visit: _____ Dentist:_____

Horse History (PLEASE be be specific and as detailed as you can be)
Was a PPE done on this horse? YES / NO Date: _____

Significant Findings: _____

_____

History of lameness? YES / NO
History of ulcers? YES / NO

History of kissing spine? YES / NO
History of Lyme disease? YES / NO

History of EPM? YES/NO

History of colic? YES / NO

History of EPM? YES / NO

History of surgery? YES / NO

Add details for any YES answers from above.

_____

Vaccines: Following 6 are REQUIRED CURRENT for training

Date of last Vaccines:

Eastern Equine Encephalomyelitis (EEE): _____

Western Equine Encephalomyelitis (WEE): _____

Tetanus: _____ West Nile Virus: _____

Equine Influenza:_____Equine Rhinopneumonitis

Rhino/EHV-1 & EHV-4): _____ Coggins: _____

Has your horse been shown or hauled in the last 30 days? _____

Behavior

Does this horse have a history of:

Bucking? YES / NO Girthy? YES / NO

Rearing? YES / NO Bolting? YES / NO

Biting? YES / NO Kicking? YES / NO

Not loading? YES / NO Accidents in wash rack or trailer? YES / NO

Has anyone ever been hurt or hospitalized around this horse? YES / NO

Details:

_____

Has this horse been in training in the past? YES / NO

How many different trainers? _____ Duration? _____

Briefly explain your reason for sending your horse to Ackerly Equestrian:

_____

_____

Rider Goals: (circle all that apply):

Show jumping	Dressage	Fox Hunting
Mounted Patrol	Trail	Groundwork
Barrels	Western Dressage	Liberty

Do you wish to show as part of your training? YES / NO
Rider skill level: Beginner / Intermediate / Advanced

Briefly Describe your horse experience:

_____
_____
_____

Do you have any medical history that affects your ability to ride? YES/NO

History of:

Cardiac issues YES?NO Seizures/Neurological? YES/NO

Knee Pain or Surgery? YES/NO Spine/Back Pain or Surgery? YES?NO

I _____Certify that all of the information listed here-in is complete and accurate to the best of my knowledge.

_____ _____

Owner Date

Desired Training Start Date: _____

This Form is not a guarantee of a stall of that date. A Deposit of $300 and a Training Contract are required to reserve a spot for training.

EMAIL 1) Completed 2 page Form, 2) Coggins Report 3) Proof of Vaccines

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