



## INDIVIDUAL PROFILE

*To be completed by parent, physician or mental health professional as appropriate*

<b>NAME OF INDIVIDUAL</b>		<b>PHONE</b>	
<b>ADDRESS</b>		<b>CITY/POSTAL CODE</b>	
<b>AGE</b>	<b>DATE OF BIRTH</b>	<b>HEIGHT</b>	<b>WEIGHT</b>
<b>GRADE</b>	<b>EA SUPPORT (CHECK ALL THAT APPLY)</b>		
	<input type="checkbox"/> <b>Part-Time</b> <input type="checkbox"/> <b>Full-Time</b> <input type="checkbox"/> <b>Academic Support</b> <input type="checkbox"/> <b>Behavioural Support</b>		

**Social Skills:**

Enjoys playing with children of _____ same age    _____ younger    _____ older	
Fears / Dislikes	
Likes / Enjoys	
Motivated by	

**If the individual finds any of the following situations to be challenging, please provide details on how we can assist them to succeed in these areas at Sunrise.**

Changing activities and/or locations	
Staying with a group during activities	
Respecting personal space and / or property of others	
Following instructions (includes respecting safety rules)	
Focusing on task / activity at hand	
Interacting socially with peers	
Comments:	

**If the individual demonstrates any of the following behaviours, please explain contributing causes and prevention / intervention strategies that you successfully employ.**

Fearfulness	
Shyness	
Easily frustrated	
Difficulty in controlling anger	
Overly assertive / aggressive behaviour	
Use of inappropriate language	
<b>Other Comments / Details</b>	

Reading Level /Skill: \_\_\_\_\_

Please describe supportive strategies which are effective in addressing the individual's mental health, behavioural or social-emotional needs.

Please describe how the individual's mental health, behavioural or social-emotional challenges impact him or her (ie. At home, at school, in the community).

Please indicate if the individual has experienced one (or more) of the following mental health challenges:

- Alcohol/Substance Dependence
- Anxiety Disorder (*Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Specific Phobia*)
- Autism Spectrum Disorder (ASD)
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Bi-Polar Disorder
- Borderline Personality Disorder
- Conduct Disorder
- Depression
- Dissociative Disorder (*Depersonalization Disorder, Dissociative Identify Disorder*)
- Eating Disorder (*anorexia, bulimia*)
- Fetal Alcohol Syndrome
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder
- Post-Traumatic Stress Disorder (PTSD)
- Psychotic Disorder
- Schizophrenia
- Seasonal Affective Disorder (SAD)
- Separation Anxiety Disorder
- Sensory Processing Disorder
- Sleep Disorder (*Insomnia, Narcolepsy*)
- Tourette's Disorder
- Other (please specify) \_\_\_\_\_

When was the individual diagnosed? \_\_\_\_\_ Who diagnosed the individual? \_\_\_\_\_

**Form Completed by:** \_\_\_\_\_ **Relationship to Client** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Sunrise Therapeutic Riding and Learning Centre treats all personal information as confidential and does not release it to any other organization. Any information provided may be used to decide on this patient's suitability for riding and help provide a better quality individualized program for the patient.**

**Return form to Sunrise Therapeutic Riding and Learning Centre: 6920 Conc. 1, R. R. #2, Puslinch ON N1H 6J6  
Ph. 519-837-0558 • Fax 519-837-1233 lydia@sunrise-therapeutic.ca**