

**Medicine Horse Center
Horses and Healing
Confidential Pre-Group Evaluation**

Date _____

ID: _____

(Please use the last 2 numbers of your street address or PO Box.)

Thank you for filling out this evaluation. The information will be used to support our funding so that we can keep this group low cost, and also to be sure that the group continues to be the highest quality possible.

There are no right answers, so please fill it out as honestly as possible for you in this moment. Thank you very much.

On a scale of 1-5, please indicate how frequently you are experiencing the following:

Intrusive thoughts or memories of assault, trauma (i.e. Nightmares, flashbacks, easily startled, panic attacks)

1	2	3	4	5
Never	Several times per month	Several times per week	Daily	Don't Know

Difficulty sleeping or sleeping too much

1	2	3	4	5
Never	Several times per month	Several times per week	Daily	Don't Know

Suicidal thoughts and feelings

1	2	3	4	5
Never	Several times per month	Several times per week	Daily	Don't Know

Difficulty communicating with others about assault/abuse

1	2	3	4	5
Never	Several times per month	Several times per week	Daily	Don't Know

