

4STEP EAMH
Registration
Family Participant

Parent(s) Name _____ age _____
_____ age _____

Children's Names

_____ age _____ age _____
_____ age _____ age _____
_____ age _____ age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Email: _____

Cell Phone # _____ Pager # _____

Date of Birth _____

Marital Status _____ Gender [] Male [] Female

Employer _____ Employment Status _____

School attended by children _____

Referred by _____

Presenting Issues (briefly) _____

When did these issues first become a concern? _____

What have you tried before coming to 4STEP? _____

Are you coming of your own free will and motivation? Yes No

Were you referred by someone? Yes No If yes, who? _____

I, _____ agree to pay *4 Seasons Therapeutic Equestrian Program (4STEP)* at the current rate for the services provided to me (or the participant named above for whom I have legal responsibility). I understand that I am responsible for these charges and that fees are due at the time service is provided, unless I make arrangements in advance. If grant-funded, these policies only apply to late cancellation/missed appointment fees.

Participant's Signature (or parent/guardian/responsible party) **Date**

Parent Signature **date**

Parent Signature **date**

Staff Signature **date**

Staff Signature **date**

Medical History, Emergency Information, & Health Care Consent

Parent/Guardian _____ Phone Numbers _____

*1st Emergency Contact _____ Relationship to Participant _____ Phone _____

*2nd Emergency Contact _____ Relationship to Participant _____ Phone _____

*(*participant's or parent/guardian's first choice for us to call if parent/guardian is unavailable in a medical emergency)*

Participant's Primary Physician _____ Phone Number _____

Preferred Medical Facility: _____

Emergency Medical Consent

The undersigned hereby grants to any 4STEP affiliate/employee/intern/volunteer the authority to receive information pertaining to the emergency health care of the participant named below and to make emergency health care decisions with respect to the participant if the undersigned is unavailable to obtain such information or make such decisions.

Please list all individuals in which emergency medical care may be given

Phone: _____ Address: _____

Date: _____ Signature: _____
(parent, guardian, or adult Participant)

+++++

Emergency Medical Non-Consent

If the undersigned does not desire to grant any 4STEP affiliate/employee/intern/volunteer information or to make health care decisions for the participant if the undersigned is unavailable, please initial on the line below and state the procedures to be followed if the participant becomes ill or is involved in an accident and the undersigned is unavailable.

Please list all individuals in which emergency medical care may NOT be given

_____ I Do Not Consent to any 4STEP affiliate/employee/intern/volunteer obtaining health care information or making emergency health care decisions concerning the Participant.

Procedures to be followed: _____

Date: _____ Signature: _____
(parent, guardian, or adult participant)

Assessment

Participant's Name: _____ Date of Birth: _____
 Today's Date: _____

Goals for session. Please check all that apply. Use blank lines below to write any issues that were not covered.

<input type="checkbox"/>	Grief	<input type="checkbox"/>	Family relationships
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Group relationships
<input type="checkbox"/>	Social Anxiety	<input type="checkbox"/>	Cohesiveness (how well people get along)
<input type="checkbox"/>	Communication	<input type="checkbox"/>	Sibling issues
<input type="checkbox"/>	Parent/Child issues	<input type="checkbox"/>	Discipline issues
<input type="checkbox"/>	Premarital issues	<input type="checkbox"/>	Marital issues
<input type="checkbox"/>	Autism	<input type="checkbox"/>	ODD (oppositional defiant disorder)
<input type="checkbox"/>	CD (conduct disorder)	<input type="checkbox"/>	Social skills
<input type="checkbox"/>	Coping with life issues	<input type="checkbox"/>	Making big changes
<input type="checkbox"/>	Mental Health Issues	<input type="checkbox"/>	Work Environment Issues

Other _____

Now that you've identified some of the issues you would like to work on, please give us as much information about those issues as you feel necessary. *(For example: if you marked "Marital issues" – do you want to work on communication, fighting, parenting, splitting up chores, preventing divorce, growing closer together, etc)*

Partnering Agency

Only needed if services are paid through another agency or if you are mandated to participate.

To be filled out by Agency.

Participant Name: _____ DOB: _____ Age: _____
Date: _____

Legal Guardian: _____ Chart # _____
Address: _____

Phone: _____ check if okay to leave message

Primary Caretaker if different from above: _____
Persons present at intake: _____

Fill in all applicable information:

Court Counselor : _____ County : _____
Contact # _____ Email: _____

Referral Program/Company: _____
Contact: _____ Contact # _____
Email: _____

Children and Youth Case Manager _____
Contact # _____ Email: _____

Probation Officer: _____ Contact # _____
Email: _____

Other: _____

Will persons of the partnering agency be attending therapy sessions? Yes No

If yes, please contact Laurel Patton prior to session for session rules, regulations and expectations.

Reasons for Referral:

Signature of Referral Source

Date

Physical/Mental/Emotional Health History

Medical/Health Issues: _____

Known Diagnosis: _____

If applicable to why you are seeking services, please fill in the below information.

History of Abuse (physical, sexual, emotional, neglect)?: _____

Substance Abuse History – Check all that apply

DRUG	Initial	FIRST USE	CURRENT USE FREQ/AMNT	LAST USE	TOLERANCE
ALCOHOL					<input type="checkbox"/> yes <input type="checkbox"/> no
MARIJUANA					<input type="checkbox"/> yes <input type="checkbox"/> no
COCAINE					<input type="checkbox"/> yes <input type="checkbox"/> no
STIMULANTS					<input type="checkbox"/> yes <input type="checkbox"/> no
HALLUCINOGENS					<input type="checkbox"/> yes <input type="checkbox"/> no
HEROIN					<input type="checkbox"/> yes <input type="checkbox"/> no
INHALANTS					<input type="checkbox"/> yes <input type="checkbox"/> no
OTHER _____					<input type="checkbox"/> yes <input type="checkbox"/> no

Physical problems associated with drug use: _____
 Family history of substance abuse: _____
 Previous substance abuse treatment: _____
 Response to Treatment: _____

Support groups: AA NA Has sponsor Attends Meetings Family
 Friends Other

Legal: _____

If applicable to why you are seeking services please fill in below information.

Mental Status :

Mood: _____ appropriate to situation, _____

Affect: _____ appropriate to situation, _____

Judgment: _____ age appropriate, _____

Speech: _____ logical/ goal oriented, _____ Insight: _____ age appropriate, _____

Thought Content/Process: _____ normal, _____ Orientation: _____ x 4, _____

Motor activity: _____ unremarkable, _____ Comments; _____

-Self Injury past/present: _____

-Self –mutilation: _____

- Aggression Past/present: _____

Problems with:

-Sleep: _____ Encopresis / Enuresis _____

-Appetite / weight changes: _____

-Energy/Motivation/Self Care: _____

Participant Signature (14+years old)

Parent/Caregiver Signature

Date

Date

4STEP Staff Signature

Date

Discharge Summary

To be filled out by 4STEP staff at the conclusion of services

Participant's Name: _____ Date of Birth: _____ Age: _____

Parent/Guardian Name: _____

Complete A or B:

A Discharge and Closed Case at 4STEP.

Date of First Session: _____ Date of Last Session: _____

Number of Sessions: _____ Type of Termination: _____

Referral at Termination: _____

OR

B Discharge and Transfer to Another Program

Organization: _____ Responsible Person: _____

Treatment Goals:

1. _____

2. _____

3. _____

Interventions (check all that apply):

Individual Session Couples Session Family Session Group Session

Emergency Service Other: _____

Were Goals Met? (check one for each):

yes no N/A 1. _____

yes no N/A 2. _____

yes no N/A 3. _____

Compliance with Treatment (check one):

good needs reinforcement poor Comments: _____

Description of Closing Session:

Disposition/ Prognosis:

_____ (next page)

Participant's Name: _____ Date of Birth: _____ Age: _____

Assessment of Dangerousness to Self or Others:

Is there a history of dangerousness to self or others? ___yes ___no

If yes, indicate present status: _____

Ever involuntarily committed? ___yes ___no

Consults/ Referrals:

Follow Up Contact:

Signature of 4STEP Staff

Date

4STEP

Participant Rights and Responsibilities

Participant Rights

- | | |
|--|--|
| <ul style="list-style-type: none"> ◆ To receive considerate and respectful services. ◆ To receive services which demonstrate sensitivity to and respect for diverse cultural backgrounds. ◆ To receive services without regard to ethnicity, sex, age, handicapping condition, national origin, sexual orientation or economic status. ◆ To receive current and complete information concerning treatment in terms he/she can understand from the members of the professional staff assigned to his/her case. ◆ To know by name, specialty, and qualifications the members of staff assigned to his/her case. ◆ To have the consideration of privacy and individuality as it relates to social, religious and psychological well being. ◆ To have the respectfulness and privacy as it relates to his/her individual care program. Case discussion, consultation, examination, and treatment are confidential and are conducted discreetly. ◆ To obtain information on the relationship of 4STEP to other health care and related agencies insofar as his/her care is concerned. ◆ To be fully informed, prior to or at the time of his/her initial appointment, of services available and of related charges. ◆ To participate in the planning of his/her treatment to be fully informed of any risks or hazards associated with his/her treatment, to refuse treatment, and to refuse to participate in experimental research. | <ul style="list-style-type: none"> ◆ To not be arbitrarily discharged, or transferred to another service provider. Participants may be transferred or discharged only for clinical reasons, for his/her welfare, for other Participants' welfare, or for nonpayment of services. Reasonable advance notice or any transfer or discharge must be given to a family/Participant. ◆ To be free from mental and physical abuse, neglect, and exploitation and be free from chemical and physical restraints, except in emergencies, or as authorized in writing by his/her physician or other appropriately licensed professionals for a specified and limited period of time, and when necessary to protect the Participant from injury to him/herself or to others. ◆ No Participant/family shall be required to provide services for 4STEP. To have the assurance of confidential treatment of his/her clinical records and may approve or refuse their release to any individual outside 4STEP, except as otherwise provided by law, or a third party payment contract. ◆ To expect a reasonable response to his/her requests. ◆ To expect reasonable continuity of care. |
|--|--|

Participant Responsibilities

- ◆ To keep appointment or notify 4STEP of necessary cancellations 24 hours in advance.
- ◆ To pay for services to the extent that he/she is able. Services may be refused if a participant/family is able but unwilling to pay.
- ◆ To inform 4STEP of relevant changes in location or status – address, telephone number, etc.
- ◆ To follow through on service plan recommendations and procedures to which he/she had agreed or to specifically communicate his/her withdrawal of consent to any 4STEP staff member.

**To report any problems or changes, please contact your facilitator. If you believe you have been denied any of the above rights, you may contact 4STEP. by mail at:
60 Four Seasons Lane McClure, PA 17841**

I have been given, have read and understand the **Participants Rights** and **Participant Responsibility** Forms.

Parent Guardian _____

Date _____

Parent Guardian _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____

Signature _____

Date _____