

**EAL & EAMH  
Registration  
Individual Participant**

Parent(s) Name \_\_\_\_\_ age \_\_\_\_\_  
\_\_\_\_\_ age \_\_\_\_\_  
Youth's Name \_\_\_\_\_ age \_\_\_\_\_ DOB \_\_\_\_\_

**CONTACT INFO**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

**YOUTH INFO**

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? \_\_\_\_\_  
\_\_\_\_\_

**PLEASE USE THE BELOW SPACE TO DISCUSS ANYTHING THAT YOU BELIEVE  
WOULD BE NECESSARY FOR OUR STAFF TO KNOW BEFORE STARTING SERVICES.**

You may use the back of this page if you need more space.

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 \_\_\_\_\_

\*1<sup>st</sup> Emergency Contact \_\_\_\_\_ Relationship to Participant \_\_\_\_\_ Phone \_\_\_\_\_

\*2<sup>nd</sup> 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)  
Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(youth if 14+ years old)

+++++

**Please take a few minutes and chose your top 3 Goals**

**Parental top 3 goals for youth (not applicable if participant is an adult.)**

- 1
- 2
- 3

**Participant top 3 goals**

- 1
- 2
- 3

## 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
<input type="checkbox"/>	Anger Management	<input type="checkbox"/>	Accepting (please state specific)

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 come

**Participant Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Legal Guardian:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ check each if okay to leave message

**Primary Caretaker if different from above:** \_\_\_\_\_

Fill in all applicable information:

**Referral Program/Company:** \_\_\_\_\_

**Contact:** \_\_\_\_\_ **Contact #** \_\_\_\_\_

**County** \_\_\_\_\_

**Children and Youth Case Manager** \_\_\_\_\_

**Contact #** \_\_\_\_\_

**Probation Officer:** \_\_\_\_\_ **Contact #** \_\_\_\_\_

**Other:**

\_\_\_\_\_

**Number of sessions required (3 minimum)** \_\_\_\_\_

### Reasons for Referral: (goals)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**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"><li>◆ To receive considerate and respectful services.</li><li>◆ To receive services which demonstrate sensitivity to and respect for diverse cultural backgrounds.</li><li>◆ To receive services without regard to ethnicity, sex, age, handicapping condition, national origin, sexual orientation or economic status.</li><li>◆ 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.</li><li>◆ To know by name, specialty, and qualifications the members of staff assigned to his/her case.</li><li>◆ To have the consideration of privacy and individuality as it relates to social, religious and psychological well being.</li><li>◆ 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.</li><li>◆ To obtain information on the relationship of 4STEP to other health care and related agencies insofar as his/her care is concerned.</li><li>◆ To be fully informed, prior to or at the time of his/her initial appointment, of services available and of related charges.</li><li>◆ 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.</li></ul>	<ul style="list-style-type: none"><li>◆ 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 transferor discharge must be given to a family/Participant.</li><li>◆ 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.</li><li>◆ 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.</li><li>◆ To expect a reasonable response to his/her requests.</li><li>◆ To expect reasonable continuity of care.</li></ul>
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## Participant Responsibilities

- ◆ To keep appointment or notify 4STEP of necessary cancellations 24 hours in advance.
- ◆ To pay for services to the extent that is contracted ahead of time. Services may be refused if payment is not received.
- ◆ Payment is required at time service is delivered.
- ◆ 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**

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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 \_\_\_\_\_