



4STEP 4 Seasons
Therapeutic
Equitation Program

REGISTRATION

Participant Name: _____ Last 4 digits S.S. # : XXX-XX-_____

Date of Birth: _____ Grade _____

Primary Phone Number: _____ Email Address _____

Secondary Phone Number : _____ Yes, I want to help 4STEP conserve paper
And reduce costs. 4STEP may contact
me through email.

Address: _____

Caregiver's/Parent's Names: _____

Siblings (and ages):

Reason for referral: Physical Health Mental Health Behavioral Health
Description of Concerns and/or goals:

Diagnosis: _____

Likes and Dislikes:

Special Needs or Limitations:

Religious affiliation (optional): _____

Referred through: _____

Parent Signature: _____ Date _____

Client Signature: _____ Date _____
(if 14+)