Leg Up Equine Assisted Psychotherapy Intake Form

Tennessee - Warning - Under Tennessee Law, an equine professional is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities, pursuant to Tennessee Code Annotated, title 44, chapter 20.

Leg Up at Hillview Farm, Inc.

Angelina V. Wallace, LPC-MHSP, NCC, EMDR, EAGALA Certified Professional

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Please complete the following information about yourself:

Name:_____ **Date of Birth:** _____**SS #** _____

Address:_____

Street **City, State, Zip**

Phone:(___)_____ **Okay to send text/voicemails regarding appointments? __ Yes __ No**

Alt. Phn:(___)_____ **Okay to send text/voicemails regarding appointments? __ Yes __ No**

Email:_____ **Okay to send emails regarding appointments? __ Yes __ No**

Emergency contact_____ **Phone (___)**_____

***By listing someone as your emergency contact, you agree to release information to this person regarding your personal safety should the need ever present itself.**

If Minor, name of Parent or Guardian:_____

Parent/Guardian Phone and Email (if not listed above):_____

Employment/School Information

Employer/School:_____

Address:_____

Job Description: _____

Any work or school related stressors?_____

Highest Level of Education completed: _____

Military Service? ___ Yes ___ No

Marital Status _____ **Number of years** _____

Spouse/Significant Other Name:_____ **Phone:**_____

Is it Okay to speak with your spouse/significant other regarding your treatment?

__Yes __No

Are you taking any prescription drugs at this time? ___Yes ___No

Prescribed by:_____

If yes, please list with dosage: for what purpose? For how long?

_____

_____

_____

_____

Have the medications helped?

_____

Medical Primary Care or Family Physician:_____**Phone** _____

Address:

_____

Do I have permission to speak with your doctor if necessary for your treatment?

___Yes ___No

Psychiatrist Name:_____ Phone: _____

Address:_____

Do I have permission to speak with your psychiatrist if necessary for your treatment?
___Yes ___No
Is there anyone else you would like to give permission for me to speak with or send communication in regard to your treatment? Please list them below:
Name:_____ Phone:(____)_____Email: _____
Reason for ROI (Release of Information):_____
_____
Name:_____ Phone:(____)_____Email: _____
Reason for ROI (Release of Information):_____
_____

The following questions are designed to help understand your background. Please complete them as they apply to you.

Please describe any previous psychotherapy treatment:_____
_____
_____

(If you would like to give me permission to speak with your previous counselor, please list their information below)

Name:_____ Phone:(____)_____Email: _____

Any significant changes in your life in the past year? If yes, please describe:_____

_____

Do you exercise? If yes, please describe:_____

How often? _____

Do you have any sleep concerns? If yes, please describe: _____

_____

Any medical/health related concerns that we need to be made aware of? If yes, please describe: _____

_____

Any legal concerns? If yes, please describe: _____

Do you drink alcohol? If yes, how often/how many drinks per time?_____

Current Symptoms (Please Circle any/all that apply)

Anxiety/Stress	**Depressed Mood**	**Fatigue**	**Headaches**
Repetitive thoughts	**Low Self-Esteem**	**Insomnia**	**Panic Attacks**
Body Image Issues	**Indecisiveness**	**Guilt/Shame**	**Poor Memory**
Impulsiveness	**Nightmares**	**Flashbacks**	**Suicidal Thoughts**
Hallucinations	**Sadness**	**Intrusive Thoughts**	**Homicidal thoughts**
Racing Thoughts	**Shyness**	**Sexual Dysfunction**	**Concentration issues**
Risky Behaviors	**Restlessness**	**Excitability**	**School/Work trouble**
Self Injury	**Rage/Anger**	**Loss of Time**	**Loss of interest in activities**
Worthlessness	**Stomach Issues**	**Worry**	**Change in eating habits**
Nausea	**Tearfulness**	**Irritability**	**Tension**
Repetitive Behaviors	**Sleep not refreshing/wake often**		**Intrusive Thoughts**

Other (please list):_____
_____
_____
_____

Family history of drug/alcohol abuse? If yes, please describe below:
Self: _____
Father: _____
Mother: _____
Other:_____

History of abuse or trauma to you or brothers/sisters? ____yes ___no
Please describe briefly:_____
_____
_____

If you are or have been under psychiatric care or hospitalization, please describe:_____

_____

_____

Any physical complaints now or in the past that have affected your life? __ Yes ___No
If yes, please describe:_____

_____

_____

Any suicidal thoughts or attempts? ___ Yes _____ No

If yes, how recent? _____
Please describe:_____

_____

_____

Please describe briefly why you are seeking Equine Assisted Psychotherapy:_____

_____

_____

What would you like to happen?

_____

_____

Have you ever been around horses in the past? If yes, please describe:

_____

Referred by: _____

Hillview Farm Clinical Policies and Procedures

Introduction: When we agree to enter into a therapeutic treatment relationship we accept certain obligations. You have the right to our professional time and abilities in service of your treatment during your scheduled time. You have the right to be informed of the benefits and risks of treatment, and you may consent to or decline the treatment offered. You have a qualified right to privacy. In return we expect you to cooperate with our plan of treatment and to attend appointments as scheduled. If you are unable to attend a scheduled appointment, you must inform us 24 hours prior in order to avoid a late-cancellation fee.

Initial evaluation/Phone consultation: The initial evaluation will begin with me contacting you by phone to discuss treatment needs and equine assisted therapy. At the conclusion of the phone evaluation I will recommend how we can work together or suggest an alternative resource if indicated.

Therapeutic benefits/risks: Equine Assisted Psychotherapy sessions are 50-60 minutes in length, facilitated by a Mental Health Specialist and an Equine Specialist; at times there may be an Intern assisting with sessions. Our goal is to provide the opportunity to interact with horses in a way that is therapeutic and as safe as possible. Horses are herd animals, and their responses and behaviors can reflect that of our own relationships. Horses are also prey animals, which means they must stay mindful of safety concerns for themselves and their herd; giving them an incredible ability to provide us with insight into our own trauma or stress responses. Therapy is helpful for dealing with anxiety and emotional pain, however, processing negative experiences can be stressful at first. Participants often begin to experience change in their lives as a result of the therapeutic process, and change can have an impact on significant relationships.

Individual, Couples, Family, and/or Group Therapy: Sessions are 50-60 minutes in length. Group sessions must have a minimum of 5 participants, and meet weekly for several weeks. Group members are expected to respect other participant's confidentiality.

Corporate Groups: 90 minutes for up to 15 participants. Larger group accommodations can be discussed.

Medication Management: If you feel you need medication and do not have either a Primary Care Provider or a Psychiatrist, we would be happy to refer you to an appropriate medication management provider.

Termination: Termination is an integral part of psychotherapy. It is important that you allow yourself sufficient time to reflect upon the work you have done and how you will continue making healthy choices. Pre and post surveys can help us in evaluating our work together, and you may be asked to fill these out at times.

Phone Contact: The phone will not be answered during therapy sessions but messages may be left or text messages sent. Phone calls and texts will be returned as soon as possible, but if you are in need of emergent care please contact 911. If you are experiencing a mental health emergency or crisis and need immediate assistance, please either contact the Suicide Prevention Lifeline at 800-273-TALK (8255) or 911.

Cancellations: In order to avoid late-cancellation charges, please contact us 24 hours before your scheduled appointment to cancel. We have reserved a spot for you and need to be able to allow someone else the time if you will not be able to attend.

Fees: Fees for each session must be paid before the session will begin.

Miscellaneous Fees: We prefer not to be involved in legal testimony. If required to participate on your behalf, fee for forensic work is $200 per hour PLUS $300 per hour for consultation with another professional counselor and legal counsel.

Clients under age 18: In the case of minors, parents or legal guardians have access to their child's records, unless the child is emancipated. However, the most effective therapeutic treatment requires client's trust in the therapist, and confidentiality is a high priority.

Confidentiality: We understand that client confidentiality is a vital component of successful therapeutic treatment. All staff have been trained regarding HIPAA guidelines and the ACA Code of Ethics regarding client confidentiality and understand that your privacy is of utmost importance. Information or session content will never be disclosed to any unauthorized person or group.

- Information about you may be disclosed under two categories:
  - Authorized Disclosures: These disclosures require your written permission. You would state the information to be disclosed, to whom I should disclose it. You have the right to revoke in writing your authorization.

- Required Disclosures: These disclosures involve circumstances involving public policy concerns that compete with your right to maintain the confidentiality of your personal information. In certain situations information must be released with or without your permission: (a) Emergencies where there may be a danger to yourself or others and a reasonable safety plan cannot be completed. (b) Child or Elder abuse. (c) If a court of law issues a legitimate subpoena requesting information.

Informed Consent: Clients have the freedom to choose whether to enter into or remain in a counseling relationship. If at any time you feel that you would like to discontinue treatment at Hillview Farm that is your right. Signing this intake form means that you consent to counseling with Angelina V Wallace, LPC-MHSP, who is certified by the State of Tennessee as a Licensed Professional Counselor-Mental Health Service Provider. You will have opportunities throughout the counseling to discuss with Ms Wallace the nature and scope of your problems, her initial and ongoing evaluations, the treatment plan with specific goals, any recommendations for adjunctive evaluation or treatment, progress and prognosis, and foreseeable risks of treatment. If the counseling relationship is terminated at any time by client or counselor, referrals for continued treatment options will be provided by Hillview Farm.

By signing below, I testify that I have read, understand, and agree to abide by all of the requirements provided above and give my consent for treatment at Hillview Farm, Inc.

Name of Participant (Please Print):_____ **Date:** _____

Signature of Participant/Parent Guardian if Under 18: _____

Therapist Signature:_____ **Date:** _____