

# A N I M A L S A S N A T U R A L T H E R A P Y

721 Van Wyck Road • Bellingham, WA • 98226

Phone/Fax: 360-671-3509 • www.animalsasnaturaltherapy.org

# Veteran Equine Program Registration

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/Phone (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liability Release:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Participant’s name) would like to participate in Animals as Natural Therapy programs. I acknowledge the risks and potential for risks of horse and farm activities. However, I feel that the possible benefits to myself/ my son/ my daughter/ my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Windy Acres and Animals as Natural Therapy, Inc., its Board of Directors, Instructors, Therapists, Volunteers and/or Employees for any and all injuries and/or losses I/ my son/ my daughter/ my ward may sustain while participating in Animals as Natural Therapy programming. I understand that these programs may include therapeutic counseling.

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Guardian

**Photo Release (OPTIONAL):**

I hereby consent to and authorize the use and reproduction by Animals as Natural Therapy of any and all photographs and any other audiovisual materials taken of me/ my son/ my daughter/ my ward for promotional printed materials, educational activities or for any other use for the benefit of the program.

Date: \_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Guardian

**Consent for Treatment and Release of Liability for EAMHT**

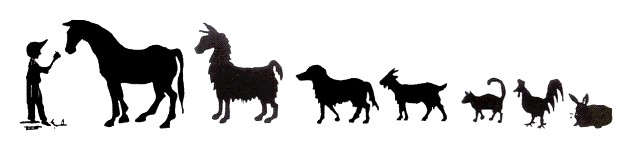
Although every effort will be made to avoid accident and injury, NO LIABILITY can be accepted by any of the organizations concerned including Animals as Natural Therapy and/or Joaquin Aguirre, MA, Certified Counselor, its officers, trustees, agents, employees, each and every one of its members and associates, and the property owners upon whose land the EAMHT sessions are conducted.

“I request and consent to treatment that may include EAMHT. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including Animals as Natural Therapy and/or Joaquin Aguirre, MA, Certified Counselor.”

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Guardian

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# Participant’s Authorization for Emergency Medical Treatment

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Animals as Natural Therapy to secure and retain medical treatment and transportation if needed.

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

In case of emergency, contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Consent Plan

This authorization includes x-ray, surgery, hospitalization, and medication and any treatment procedure deemed “lifesaving” by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant, Parent or Guardian

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event of emergency treatment/aid is required, I wish the following procedures to take place:

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Participant’s Medical History

Complete information is needed to insure instructor awareness and sensitivity to your behavior and needs and will not be used to screen out participants.

(Explain “yes” answers below) Yes No

|  |
| --- |
| 1. Any recent injury, illness, or infectious disease? |
| 2. Chronic recurring illness/condition? |
| 3. Frequent headaches? |
| 4. Ever had head injury? |
| 5. Wear glasses, contacts, or protective eyewear? |
| 6. Ever passed out during or after exercise? |
| 7. Ever had seizures? |
| 8. Chest pain during or after exercise? |
| 9. High blood pressure? |
| 10. Back problems? |
| 11. Joint problems (e.g., knees, ankles)? |
| 12. Orthodontic appliance or headgear being used? |
| 13. Any skin problems (e.g., allergies, rash, hives)? |
| 14. Diabetic? |
| 15. Asthmatic? |
| 16. ADD/ADHD diagnosed? |
| 17. Short or long-term memory impairment? |
| 18. Tendencies toward emotional/violent outburst or inflicting harm to self, others or animals? |

Please explain any “yes” answers, noting the number of the question.

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

|  |
| --- |
| Date of last Tetanus: |
| Known allergies: |
| Reaction to bee stings: |
| Medications that will be taken during visits or to be aware of in case of an emergency: |
| Is there any health reason to limit your activities? |
| Is there any general health concern not listed that would be helpful for us to know? |
| What would you most like to experience with Animals as Natural Therapy: |

**Consent for Treatment and Release of Liability for EMHT**

**Animals as Natural Therapy**

**721 Van Wyck Road**

**Bellingham, WA 98226**

**360-671-3509**

**“No child can be accepted for equine assisted mental health therapy (EAMHT) until all forms have been completed by the parent/ guardian. If the participant is of legal age and mentally competent, he/she may complete the forms without a parent or guardians signature.”**

**“Although every effort will be made to avoid accident and injury, no liability can be accepted by any of the organizations concerned including Animals as Natural Therapy and/ or Jack (Joaquin) Aguirre M.A., LMFT, its officers, trustees, agents, employees, each and every one of its members and associates, the property owners upon whose land the EAMHT sessions are conducted.”**

**I request and consent to treatment that may include EAMHT. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including Animals as Natural Therapy and or/Jack (Joaquin) Aguirre M.A., LMFT.**

**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant or Parent/Guardian**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Jack S. Aguirre M.A., LMFT

Animals as Natural Therapy Therapist

360-318-6375

Disclosure Form

Washington State License Counselor # LF 00002681

**Type and Length of Counseling Provided:**

Welcome to Animals as Natural Therapy! I look forward to working with you and would like to familiarize you with my background, and counseling approach so that you may be an informed client. We offer counseling to individuals, couples, families and groups. Sessions for counseling individuals are up to 50 minutes and groups approximately 1 ½ hours. The number of sessions will be based on your eligibility and also been determined between the two of us.

These sessions are designed to assist you in challenges you are facing in life. While participating in counseling, you may experience various feelings which may cause some distress. However, if you are concerned that we are not working toward your goals, you are encouraged to address these concerns so we can address them together.

**Procedure:** I work with clients by appointment. Please arrive on time for sessions. As a courtesy to me and others who may wish to schedule, please give as much notice as possible if you need to cancel or change appointment(s). Clients will be expected to pay a no-show late cancellation fee unless 24-hour notice is given. Sue Swank, Bookkeeper, will handle all billing.

**Emergencies**: if you find yourself in crisis, please contact me via the numbers I have provided, or contact one of the following crisis numbers: Care Crisis Response: **1-800-584-3578/Call 911/Get to the nearest hospital Emergency Room**.

**Theoretical Orientation**: My theoretical orientation is eclectic in nature and utilizes, when needed, Family Systems approaches, Cognitive Behavioral and Psychotherapeutic approaches. My techniques include reflection on behavior, ways to correct maladaptive behavior as well as thoughts, and integration of new learning, including acquisition of and self-mastery of coping skills.

**Education and Training**: My Bachelor’s degree was completed in Santa Barbara, California, at Westmont College, while my master’s in counseling psychology with an emphasis in Marriage, Family and Child Counseling was earned at Chapman University in Orange, California. I acquired a Washington state license as a Marriage and Family Therapist in 2008. My training, education, and experience includes the schools mentioned and in community mental health since 1987, as well as in a variety of settings including inpatient psychiatric hospitals, private practice, and outpatient services. The challenges my patients or clients have faced include traumas from abuse, physical injury, war, and family chaos. My continuing education includes focus on the treatment of PTSD, Family Systems, and cognitive distortions. I have completed training as a Trauma Response Specialist, Biofeedback and Neurofeedback with a certificate of completion in each.

**Ethics and Professional Conduct**: We will uphold strict ethical standards in our work with you. However, if you feel your therapist has acted in an unethical or unprofessional manner, you may contact the department of health counselor programs division in Olympia. Contact information is as follows: Health Professions Quality Assurance; Customer Service Center; PO Box 47865; Olympia, WA 98504; Email: hpqa.csc@doh.wa.gov; phone: (360)236-4700 Fax: 360-236-4818

Please feel free to ask questions or discuss any part of this disclosure form with me. Please sign this form, indicating that you have read and understand its contents.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Guardian) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Therapist) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_