Office Use Only:
Date:_____

HEROES HELPING WITH HORSEPOWER
CLIENT APPLICATION

GENERAL INFORMATION_____ Application Date:_____

Applicant Name: _____ Check: □ Male □ Female

Height: _____ Weight:_____ Date of Birth:____/_____/_____ Age:_____

Ethnicity: _____ Phone: (Home) _____ T Shirt Size_____

Not required; for grant application purposes only.

(Cell) _____Address: _____

City:_____ State:_____ Zip Code:_____

E-Mail:_____

Used for notification, newsletters, etc.

Branch of Service_____ MOS_____ Retirement date_____

Primary Diagnosis: _____

Spouse's name (if applicable):_____ Number:_____

Referral Source: _____

Previous experience with horses or therapeutic riding? □ Yes □ No

Children or dependents? □ Yes □ No Name(s): _____ Age:_____

_____ Age:_____ _____ Age:_____

SCHEDULING INFORMATION

SESSIONS ARE BY APPOINTMENT. EACH SESSION LASTS 90 mins.

- In 2022, a **No Show Policy** was created. We have many new participants and want to accommodate as many of them as we can. Therefore, we do require a 3-hour notice if you are unable to make your scheduled lesson. **The penalty for not giving notice will be the full lesson price.** **We are aware that emergency situations can occur and will do our best to accommodate those cases.*
- When temperatures are above 85°, below 15° or there is a risk for severe weather, - we will do our best to reschedule or will need to cancel for everyone's safety. We will notify riders 3 hours prior to their lesson if we need to cancel or reschedule.

Goals (reason for applying; what would you like to see accomplished):

_____

_____

APPLICANT HEALTH HISTORY

Please indicate current/past problems in the following areas (Please include environmental simulants, if any):

Vision: _____

Hearing: _____

Sensation: _____

Communication: _____

Heart: _____

Breathing: _____

Digestion: _____

Elimination: _____

Circulation: _____

Emotional: _____

Behavioral: _____

Pain: _____

Bone/Joint: _____

Muscular: _____

Thinking/Cognitive: _____

Allergies: _____

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APPLICANT HEALTH HISTORY (continued)

Current Medications of Applicant (over-the counter included):

_____

_____

_____

Please describe applicant's FUNCTIONAL abilities and difficulties, such as: mobility skills (transfers, walking, wheelchair use, driving/bus riding):

_____

_____

***Please describe assistance required or equipment needed:**

_____

_____

Please describe applicant's SOCIAL abilities and difficulties, such as: work/school (grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.):

_____

_____

_____

***Please describe assistance required or equipment needed:**

_____

_____

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APPLICANT INFORMATION

Goals (reason for applying; what would you like to see accomplished):

_____

_____

_____

Please tell us about the applicant. (Likes: Favorite food, hobbies, pets, home life, siblings) (Dislikes: pets, sounds, etc.):

_____

_____

_____

What types of things work best for the applicant in terms of rewards and motivation?

_____

_____

_____

How does the applicant best communicate with others?

- □ Spoken Language
- □ Written Language
- □ Sign Language □ASL □PSE
- □ Communication device
- □ Combination of the above (please describe)

_____

_____

Does the applicant use:

- ❏ Behavioral: agitation, irritability, hostility, hypervigilance, self-destructive behavior, or social isolation
- ❏ Psychological: flashback, fear, severe anxiety, depression or mistrust
- ❏ Mood: loss of interest or pleasure in activities, guilt, or loneliness
- ❏ Sleep: insomnia or nightmares
- ❏ Emotional detachment or unwanted thoughts

□ Self Regulatory Behavior (Please describe how the applicant uses this self soothing behavior):

_____

_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Applicant's Name: _____ Date of Birth: ____/____/_____ Phone: (___)_____

Applicant's Address: _____ City: _____ State:____ Zip Code:_____

Medical Facility:_____ Phone: (_____)_____

Physician's Name:_____ Phone: (_____)_____

Health Insurance Company:_____ Policy #:_____

Allergies to Medications:_____

_____

Current Medications: _____

Emergency Contacts:

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

Name: _____ Relation:_____ Phone: (____)_____

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 Helping With Horsepower™ to:

1. Secure and retain medical treatment and transportation if needed.
2. Release volunteer records upon request to the authorized individual or agency involved in the medical emergency treatment.

*(Please sign the CONSENT PLAN or the NON-CONSENT PLAN on next page)

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Consent Plan

I ***DO*** give authorization that may include x-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the emergency contact person(s) above is unable to be reached.

Signature: _____ Date: ____/_____/_____

Print: _____

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 emergency treatment aid is required; I wish the following procedures to take place:

_____

_____

_____

Signature: _____ Date: _____/_____/_____

Print: _____

PHOTO AND VIDEO CONSENT

I, _____ consent_____ or **do not** consent_____ to authorize the use and reproduction by Helping With Horsepower™ at Reclamation-Ranch of any and all photographs, video/audio materials taken of me for the purpose of on-going studies, educational activities, exhibitions, promotional materials or for any other use for the benefit of the program.

Signature: _____ Date: _____/_____/_____

Print: _____

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Helping With Horsepower™ at Reclamation-Ranch
RELEASE OF LIABILITY

This Release of Liability is made and entered into on this date _____/_____/_____ and for thereafter between Reclamation-Ranch, Crystal Young (Director) and Helping With Horsepower™, its volunteers, board members, staff, employees, and _____ (The Participant);

In return for use, today and on future dates, of the property, facility and services of the Director, the Participant, his heirs, assigns and legal representatives, hereby expressly agree to the following:

1. It is the responsibility of the Participant to carry full and complete insurance coverage on his/her horse if he/she owns or leases one, personal property, and him/herself.
2. Participant agrees to assume Any And All Risks Involved In Or Arising From Participant's Use Of Or Presence Upon HWH, and the Property And Facility including without limitation the risk of death, bodily injury, property damage, all kicks, bites, collisions with vehicles, horses, or stationary objects, fire or explosion, the unavailability of emergency care, or the negligence or deliberate act of another person.
3. Participant agrees to hold HWH, the Director and all its successors, assigns, subsidiaries, franchises, affiliates, officers, directors, employees and agents completely harmless and not liable, and releases them from all liability whatsoever, and Agrees Not To Sue them on account of, or in connection with any claims, causes of action, injuries, damages, costs or expenses arising out of the Participant's use of or presence upon HWH, and the property and facility, including without limitation, those based on death, bodily injury, or property damage, including consequential damages.
4. Participant agrees to waive the protection afforded by any statute or law in any jurisdiction whose purpose, substance and/or effect is to provide that a general release shall not extend to claims, material or otherwise which the person giving the release does not know or suspect to exist at the time of executing this release.
5. Participant agrees to indemnify and defend HWH, and the Director against, and hold it harmless from any and all claims, causes of action, damages judgments, costs or expenses, including attorney's fees, which in any way arise from the Participant's use of or presence upon HWH, and the property or facility at Reclamation-Ranch.
6. Participant agrees to abide by all of HWH, and the property safety rules and regulations.
7. If Participant is using his/her horse, the horse shall be free from infection, contagious or transmittable disease. HWH, and the Director reserve the right to refuse horse if not in proper health, or is deemed dangerous or undesirable.
8. This contract is non-assignable and non-transferable, and is made and entered into in the State of South Dakota, and shall be enforced and interpreted under the laws of this State. Should any be in conflict with State law, then that clause is null and void. When HWH, the Director and Participant, or Participant's Parent or Legal Guardian if Participant is a minor, sign this contract, it will then be binding on both parties, subject to the above terms and conditions.
9. Warning: Under South Dakota law, an Equine Professional is not liable for an injury to and/or the death of a participant in equine activities resulting from the inherent risks of equine activities.

Signature: _____ Date:____/_____/_____

Print :_____

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The following forms are to be completed by the applicable physicians at the participants discretion. Choosing not to complete the following, will not affect your participation. All information shared is on a voluntary basis and to assist our team in assisting the applicant in achieving their goals and full potential through interactions with horses.

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(To be filled out by physician only)

PHYSICIAN'S PRESCRIPTION

Dear Physician:

Your patient _____ is interested in participating in supervised equestrian activities. In order to safely provide this service, our operating center requests that you complete/update the Medical History & Physician's Statement. Please note that the following conditions may suggest precautions and contraindications to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

ORTHOPEDIC

Atlantoaxial Instability - include neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossifications
Joint Subluxation Dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion / Fixation
Spinal Instability /Abnormalities

NEUROLOGIC

Hydrocephalus / Shunt
Seizure
Spina Bifida / Chiari II malformation/Tethered Cord
Hydromyelia

OTHER

Indwelling Catheters
Medications - i.e. photosensitivity
Skin Breakdown

MEDICAL/PSYCHOLOGICAL

Allergies
Animal Abuse
Physical/Sexual Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorder
Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, please feel free to contact the operating center at the address and phone indicated below. Sincerely,

Physician's Prescription

Client's Name: _____ Phone: (_____) _____

Prescription for Therapeutic Horseback Riding

Prescription, where appropriate for evaluation and treatment by a Physical, Occupational and/or Speech Therapist in conjunction with Helping With Horsepower.

Recommended Frequency: _____

Precautions: _____

Physician's Signature: _____ Date: ____/_____/_____

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Return To:

MEDICAL HISTORY & PHYSICIAN'S STATEMENT

(To be filled out by physician only)

Applicant Name:_____ Male□ Female □ Date of Birth:___/_____/_____

Height:_____ Weight:_____ Diagnosis:_____

Date of Onset: ____/_____/_____ Past/Prospective Surgeries:_____

Medications: _____

Seizure Type: _____ Controlled: □ Yes □ No Date of Last Seizure: ____/_____/_____

Shunt Present: □ Yes □ No Date of Last Revision: ____/_____/_____

Special Precautions/Needs: _____

Mobility: Independent Ambulation: □ Yes □ No Braces/Assistive Devices: _____

Assisted Ambulation: □ Yes □ No Wheelchair: □ Yes □ No

PLEASE INDICATE CURRENT/PAST DIFFICULTIES IN SYSTEMS/AREAS; INCLUDE SURGERIES:

Auditory:_____

Visual: _____

Tactile Sensation: _____

Speech: _____

Cardiac: _____

Circulatory: _____

Integumentary/Skin: _____

Immunity: _____

Pulmonary: _____

Neurologic: _____

Muscular: _____

Balance: _____

Orthopedic: _____

Allergies: _____

Learning Disability: _____

Cognitive: _____

Emotional: _____

Pain: _____

Other: _____

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above, against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (eg. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name/Title:_____ License/UPIN #:_____

Signature:_____ Date:_____/_____/_____

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PHYSICAL/OCCUPATIONAL THERAPY QUESTIONNAIRE

(To be filled out by therapist only)

Client Name: _____ DOB: ____/___/_____ Age:_____

Address: _____

Diagnosis: _____ Date of Request: ___/_____/_____

The above named client has applied for Therapeutic Equine Sessions at Helping With Horsepower™ at Reclamation-Ranch. So that we may design a riding program to best accommodate and benefit this person, we would appreciate your input. It is our intent to use our program as an extension of the services you provide; therefore, the following information is very helpful to us. We want to assimilate your goals (both short term and long term) into ours for this person.

Specific Physical Therapy Needs to Address:

Current Treatment Goals: (we set 8-10 goals and evaluate progress every 12 weeks)

Recommended Gross Motor Activities:

Any Helpful Hints for Working with This Person:

_____
Print Name

_____ _____/_____/_____
Physical/Occupational Therapist (Please Sign) **Date**

Return To:

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Release of Information

AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION FROM YOUR CLINICAL RECORD TO THE PERSON/ORGANIZATION YOU DESIGNATE THE RELEASE OF THIS INFORMATION IS COMPLETELY VOLUNTARY AND IS NOT REQUIRED FOR YOUR PARTICIPATION IN HEROES HELPING WITH HORSEPOWER Mitchell, SD.

I, _____, DOB_____,

Authorize _____(psychologist, counselor, mental health service provider, life coach, ect) to exchange information with:

Name/Organization:__Helping with Horsepower _501(c)3 _ Phone #: 605-770-2867 (Crystal Young, Program Director)__

Address:_____PO Box 51 Mitchell, SD 57301_____ Number:___45-3963128_____

Specific nature of information to be released:

_____any or all of the following _____summary of treatment

_____response to treatment/progress _____prognosis

_____presenting complaints/issues _____recommendations/suggestions

_____diagnosis and/or assessment results _____substance use/abuse information

_____initial treatment plan and goals _____other:_____

The information above is being released for the purpose of:

_____facilitating consultation and/or collaboration

_____facilitating continuity of treatment _____facilitating family involvement in treatment

I understand that:

1. This consent will automatically expire one year from signing unless a different date of expiration is specified here:_____
2. I have the right to copy and inspect the information being disclosed.
3. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Client Signature _____ Date: _____

Client Print _____

Witness Sign and print _____

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To be completed by the participant's mental health professional if applicable.

Check and describe applicable issues (indicate current or history of):

- ☐ inattention
- ☐ hyperactivity
- ☐ lack of concentration
- ☐ learning disabilities
- ☐ developmentally delayed
- ☐ mentally challenged
- ☐ boundary issues
- ☐ social skills problems
- ☐ problem with peers
- ☐ separation anxiety
- ☐ anxiety
- ☐ phobias
- ☐ aggressive
- ☐ assaultive
- ☐ manipulative
- ☐ unpredictable or dangerous behavior
- ☐ sensory impairment
- ☐ sensitivity, preferences
- ☐ tics or stereotypic behavior
- ☐ psychosomatic symptoms
- ☐ medical issues
- ☐ self-injurious behavior
- ☐ suicidal ideations
- ☐ history of runaway
- ☐ issues of parental support
- ☐ issues of family support
- ☐ sexual abuse/acting out
- ☐ history of physical abuse
- ☐ emotional abuse
- ☐ hallucinations
- ☐ delusions
- ☐ illusions
- ☐ dissociations
- ☐ substance abuse problems
- ☐ legal problems
- ☐ school problems
- ☐ history of animal abuse
- ☐ fire setting
- ☐ seizure disorder
- ☐ possible medication side effects

If you answered yes to any of the following, please provide an example or explanation.

_____

_____

_____

_____

_____

_____

_____

_____

Do changes in the applicant's environment affect their behavior? □ Never □ Sometimes □ Frequently

Please list any known environmental factors/triggers _____

_____

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How Empathetic are You? (The Toronto Empathy Questionnaire, TEQ)

Instructions

This measure of empathy assesses empathy as primarily an emotional (rather than a cognitive) process. Below is a list of statements. Please read each of the statements carefully and rate how frequently you feel or act in the manner described. Circle your answer on the response form. There are no right or wrong answers or trick questions. Please answer each question as honestly as you can.

	Never	Rarely	Sometimes	Often	Always
1. When someone else is feeling excited, I tend to get excited too.					
2. Other people's misfortunes do not disturb me a great deal.					
3. It upsets me to see someone being treated disrespectfully.					
4. I remain unaffected when someone close to me is happy					
5. I enjoy making other people feel better					
6. I have tender, concerned feelings for people less fortunate than me					
7. When a friend starts to talk about his/her problems, I try to steer the conversation towards something else					
8. I can tell when others are sad even when they do not say anything					
9. I find that I am "in tune" with other people's moods					
10. I do not feel sympathy for people who cause their own serious illnesses					
11. I become irritated when someone cries					
12. I am not really interested in how other people feel					
13. I get a strong urge to help when I see someone who is upset					
14. When I see someone being treated unfairly, I do not feel very much pity for them					
15. I find it silly for people to cry out of happiness					
16. When I see someone being taken advantage of, I feel kind of protective towards him/her					

Scoring

Never = 0, Rarely = 1, Sometimes = 2, Often = 3, Always = 4 Total score = Total items 1 to 16

Reverse Scoring

Items 2, 4, 7, 10, 11, 12, 14 and 15 are reverse-scored.

Interpretation

Higher scores indicate high levels of self-reported empathy. Males' general score for this measure ranges from 43.46 to 44.45, while females tend to score within the range of 44.62 to 48.93. Gender differences, as measured by this questionnaire are reported as being moderate.

Reference

Spreng, R. N., McKinnon, M. C., Mar, R. A., & Levine, B. (2009). The Toronto Empathy Questionnaire: Scale development and initial validation of a factor-analytic solution to multiple empathy measures. *Journal of Personality Assessment*, *91*(1), 62-71.

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