

Dream Quest Equine-Facilitated Psychotherapy

Individual and group counseling co-facilitated with horses



INFORMATION AND REGISTRATION PACKET

Dream Quest Equine-Facilitated Psychotherapy is a unique experiential counseling practice with specifically designed interactive experiences with horses, including riding. A trained therapist assists with personal exploration of feelings and behaviors and allows for the clinical interpretation of these feelings. Any individual desiring personal growth who enjoys animals and the outdoors may benefit. No previous horse experience is necessary. Appointments for children over 6 years old, teens and adults are available. Areas of expertise include:

- Assertiveness & Empowerment
- Autism
- Attention Deficit Disorder
- Confidence and Self-Esteem
- Emotional and Behavioral problems (including Anxiety, Depression and Oppositional Defiant Disorder)
- Grief and Loss
- Learning Disabilities
- Wellness

Why Equine-Facilitated Psychotherapy? Interaction with horses has amazing benefits:

- Facilitates trust and establishes rapport
- Elicits a wide range of emotional and behavioral responses
- Promotes self-confidence and personal growth
- Helps clients relax by lowering blood pressure and decreasing heart rate
- Motivates clients who may be hesitant to explore traditional counseling

L. Kay Watson is a licensed professional counselor with 20 years of experience in counseling. She has worked for Gwinnett County Public Schools for 25 years. She is certified by the National Board of Certified Counselors and licensed by the state of Georgia. She has recently completed her Specialist Degree at Georgia State University. Ms. Watson is also certified instructor with the North American Riding for the Handicapped Association and has been working with horses over 15 years. She started Dream Quest E.F.P. in November 2002.

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Information & Fees:

- Dream Quest E.F.P. is located at a family farm in Bethlehem, Georgia off Hwy. 316 between Atlanta and Athens. All appointments must be scheduled in advance.
- A Registration Packet (enclosed) must be completed and reviewed prior to riding. This includes a release of liability and signed permission to participate from a physician.
- An Intake form that includes past history and areas of concern should be completed within the first few weeks of therapy. This is typically given to parents at the first session.
- Sessions are \$90 per client for a 50-minute individual session and \$50 for a group session.
- Make checks payable to **Dream Quest EFP** at the time of the session.
- Trained volunteer horse leaders and side-walkers assist with the session based on individual needs and goals.

Session Information and Guidelines:

Please drive slowly when entering the property and make sure to close all gates!!! This is critical for the safety of the family, the clients and the animals on the farm. Proceed to the top of the hill for parking near the barn.

All clients and their family should remain close to the barn area or in the barn, away from the family home. There is a bathroom in the barn and a comfortable outdoor sitting area at a picnic table near the arena. Parents, siblings or guardians usually remain outside of the arena to watch unless involved in the session with the client and therapist. Please be courteous and save conversation with your child or staff until after the session to avoid distraction. Siblings must be directly supervised by their parent. No dogs are allowed on the property.

A typical session includes horsemanship skills such as grooming, tacking, and general horse care, as well as time riding on a horse. Additionally, there is continuous interaction between the client and the counselor, volunteers and other client(s). However, private individual sessions are also available. The counselor is available for on-going consultation with parents as a part of the session, phone conversation (up to 15 minutes without charge), and consultation with school personnel as needed.

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Each rider must wear a helmet during the lesson. We do provide helmets at the barn. Riders are required to wear long pants for leg protection. We also prefer, if possible, that the rider wear hard-soled boots with a heel rather than tennis shoes, to provide ankle support and better placement of the foot in the stirrup.

Cancellation Policy:

Please make special note that your enrollment in this program obligates you to pay each week at the time of the session. If you need to cancel a session, please do so with at least a 24-hour advance notice directly to your instructor via e-mail at or phone at 678-227-2991. **No shows, or notifications less than 24 hours in advance will be charged.** Parents will be notified in advance if the counselor needs to cancel a session. Sessions may be cancelled due to bad weather. Communication by phone will take place when it is clear that bad weather is a threat.

Questions or concerns? Please don't hesitate to ask if you need more information:

Phone contact number at 678-227-2991

E-mail kaywatson@bellsouth.net

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REGISTRATION AND RELEASE FORM

Student's Name: _____ Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Parent/Guardian: _____

Address: _____

Telephone: (Home) _____ (Business) _____

Cell Phone: _____ Email address: _____

In case of emergency: Contact _____ Phone: _____
Contact _____ Phone: _____

School/Institution presently attending _____ :

LIABILITY RELEASE(REQUIRED): _____ (name printed)
would like to participate in Dream Quest E.F.P. sessions. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/child/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 Dream Quest E.F.P., L. Kay Watson, Happy Mama Farm, Margaret and Richard Korges, Aides, and Volunteers for any and all injuries and/or losses I/my child/my ward may sustain while participating.

DATE: _____ SIGNATURE: _____

PHOTO RELEASE: _____ I hereby consent to and authorize
_____ I do not consent to nor do I authorize

the use and reproduction by Dream Quest E.F.P., Inc. of any and all photographs and any other audiovisual materials taken of me for promotional printed material, educational activities, exhibitions or for any other use for the benefit of the program.

DATE: _____ SIGNATURE: _____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process or receiving services, or while on the property of the agency, I authorize Dream Quest E.F.P. to:

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

Client's Name: _____

Parent/Guardian Name: _____

Telephone: (Home) _____ (Business) _____

Cell Phone: _____

If I cannot be reached please contact: _____

Telephone: (Home) _____ (Business) _____

Cell Phone: _____

CONSENT PLAN

This authorization includes x-rays, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person listed below cannot be reached.

DATE: _____ CONSENT SIGNATURE: _____
(Client, parent, or guardian)

Print Name: _____ Telephone: _____

Address: _____

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NON-CONSENT PLAN

I do not give 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: _____

DATE: _____ NON-CONSENT SIGNATURE: _____
(Client, parent, or guardian)

Print Name: _____ Telephone: _____

Address: _____

A COPY OF THE COMPLETED MEDICAL HISTORY (following) SHOULD BE ATTACHED TO THIS FORM

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MEDICAL HISTORY/RELEASE
(Physician's Signature)

STUDENT NAME: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

DISABILITY: _____

ADDRESS: _____

NAME OF
PARENT/GUARDIAN: _____

TELEPHONE(S) _____

—

Email address: _____

DIAGNOSIS: _____ DATE OF ONSET: _____

FOR PERSONS WITH DOWN'S SYNDROME:

Cervical x-ray for Atlanto-axial instability: ___positive ___negative

Date of x-ray: _____ Comments: _____

Tetanus immunization: ___yes ___no Date of injection: _____

Seizure type: _____ controlled: _____ Date of last seizure: _____

MEDICATIONS: _____

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PLEASE INDICATE IF PATIENT HAS A PROBLEM IN ANY OF THE FOLLOWING AREAS BY CHECKING YES OR NO. IF YES, PLEASE COMMENT, USING BACK OF PAPER IF NECESSARY.

AREA	YES	NO	Comments
AUDITORY			
VISUAL			
SPEECH			
TACTILE			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL			
VASCULAR			
VESTIBULAR/BALANCE			
ORTHOPEDIC			
ALLERGIES			
LEARNING DISABILITY			
MENTAL IMPAIRMENT			
SENSORY INTEGRATION DYSFUNCTION			
BEHAVIORAL			

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PSYCHOLOGICAL			
SURGERY			
DEVELOPMENTAL DELAY			
OTHER			

MOBILITY: Independent ambulation ___yes ___no crutches: ___yes ___no

Braces: ___yes : ___no Wheelchair: ___yes ___no

Please indicate any special precautions: _____

PHYSICIAN SECTION

In my opinion this patient can participate in supervised equestrian activities. In conjunction with these activities, I concur in the referral of the patient to a physical or occupational therapist for evaluation of abilities/limitations in performing exercises and implementing an effective equestrian program.

DATE: _____

PHYSICIAN SIGNATURE: _____

PHYSICIAN
 NAME: _____ (PRINT)

ADDRESS: _____

—

TELEPHONE(S): _____

—

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COMMENTS: _____ _____ _____

RELEASE OF INFORMATION FORM

Child's Name _____

Parent's Name _____

Kay Watson, Ed. S., L.P.C., N.C.C. has my permission to both obtain and release verbal information about my child to the following people:

Name _____ Position _____

Organization _____ Address _____

Phone number _____

Name _____ Position _____

Organization _____ Address _____

Phone number _____

Name _____ Position _____

Organization _____ Address _____

Phone number _____

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Signature

Date