THREE SPRINGS THERAPEUTIC PROGRAM

HEALTH HISTORY (ADDENDUM TO THE APPLICATION FOR ADMISSION)

Must be completed by a Parent/Guardian, Physician, or Three Springs Staff member prior to admission.

Resident's Name:_____ Age:_____ Sex:_____

Date of Birth:_____ Race:_____ SSN:_____

Parent or Guardian's Name:_____

General Health:_____ Height:_____ Weight:_____

List all Current Medications and Dosages (as well as purpose of the medication)

Medication	Dosage	Purpose

PLEASE CHECK AND EXPLAIN ANY OF THE FOLLOWING CONDITIONS THAT THE CHILD HAS A HISTORY OF:

____Any Heart Disease (If so, Please explain)_____
_____
_____
____Hernia (If so, Please explain)_____
_____
_____
____Seizure Disorder (If so, Please explain)_____
_____
_____
____Asthma (If so, Please explain)_____
_____
_____
____Diabetes (If so, Please explain)_____
_____
_____
____Any Hospitalizations (If so, Please explain)_____
_____
_____
____Back Injury (If so, Please explain)_____
_____
_____
____Any Medication for Medical Problems/Conditions (If so, Please list name of medication and dosage)_____
_____
_____

____Any Medication for Mental or Emotional Problems/Conditions (If so, Please list name of medication and dosage)_____

_____
_____
____Allergies (If so, Please list specific allergies and severity)_____
_____
____Physical or sexual abuse (If so, Please explain)_____
_____
_____
____Infectious and/or Communicable Disease (If so, Please explain)_____
_____
_____
____Any other medical conditions or information (If so, Please explain)_____
_____
_____
In the last ten (10) years, has this youth been in any hospital, clinic, sanitarium, or institution for examination, observation, diagnosis, operation or treatment? (If so, Describe and list dates)
_____
_____
_____
In the last five (5) years, has the youth had X-ray, EKG, EEG, Blood Study, or other diagnostic test? (If so, Describe)_____
_____
Has the youth been diagnosed or treated for alcohol or drug abuse in the past five (5) years? (If so, Describe including age of onset, duration of drug use, pattern of use, and consequences of use)___
_____
_____
_____

Have Biological parents, brother or sister ever had any of the following (If yes, Please explain)

Heart Disease?_____
Epilepsy?_____
Diabetes?_____
Mental Illness?_____
Substance Abuse or Dependency?(If so, Describe including age of onset, duration of drug use, pattern of use, and consequences of use)_____
_____
_____
_____

_____
Signature of Person completing this form and Date