

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: _____

Primary Care Physician: _____

Physician's Address: _____

Physician's Telephone Number: _____

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 _____