Residential Treatment Programs
Application for Admission

Date:

DEMOGRAPHIC INFORMATION

Full Name of Applicant:

Address:

City: State: Zip:

DOB: Sex ☐ male ☐ female SS#:

Was the applicant adopted? ☐ yes ☐ no If yes, at what age?

PARENT/GUARDIAN INFORMATION

Mother/guardian name: Does this person have custody of the applicant? ☐ yes ☐ no

Address:

City: State: Zip:

Contact information Home phone _____

Cell phone _____

Business phone _____

Fax _____Email _____

Father/guardian name: Does this person have custody of the applicant? ☐ yes ☐ no

Address:

City: State: Zip:

Contact information Home phone _____

Cell phone _____

Business phone _____

Fax _____Email _____

EDUCATIONAL INFORMATION

Last school attended: Current Grade:

Does the applicant have an IEP or receive special education services? ☐ yes ☐ no

Estimated IQ:

MEDICAL INFORMATION

Please describe the applicant's general health:

Date of last physical _____ Please describe findings:

Current medications:

List any allergies to foods, drugs, or other substances:

Does the applicant have any history of epileptic or convulsive disorder? □ yes □ no
If yes, please describe:

Does the applicant have any medical problems or handicaps which might interfere with full participation in our program? □ yes □ no
If yes, please describe:

LEGAL HISTORY

Has the applicant been involved with the juvenile authorities? □ yes □ no

If yes, please give details and disposition:

Is the applicant currently on probation? □ yes □ no

SUBSTANCE ABUSE INFORMATION

Has the applicant used substances? □ yes □ no □ not certain

If yes, please check the types of substances abused:

□ prescription medications
□ cocaine
□ inhalants
□ methamphetamine
□ other (please list)
□ alcohol
□ heroin
□ ecstasy
□ marijuana

Describe frequency of use:

PRESENTING PROBLEM

What recent events or behavior brought about your request for enrollment?

Briefly describe what you hope Three Springs can accomplish for the applicant:

TREATMENT HISTORY—list all mental health or substance abuse treatment the applicant has undergone. Please use an extra sheet of paper if necessary. List in order of most recent first.

1) Facility: Dates of treatment:

Name of treating professional:

Type of Treatment □ hospitalization □out-patient □day treatment □under care of psychiatrist
□under care of psychologist □substance abuse □other: _____

2) Facility: Dates of treatment:

Name of treating professional:

Type of Treatment □hospitalization □out-patient □day treatment □under care of psychiatrist
□under care of psychologist □substance abuse □other: _____

3) Facility: Dates of treatment:

Name of treating professional:

Type of Treatment □hospitalization □out-patient □day treatment □under care of psychiatrist
□under care of psychologist □substance abuse □other: _____

REFERRAL SOURCE

How did you find out about Three Springs?

□ Independent Educational Consultant
□ Another parent
□ Mental Health Professional
□ Other _____
□ Three Springs staff
□ Publication
□ Internet

Address:

City: State: Zip: Phone Number:

Along with this application, the following should be submitted for review:

- All recent diagnostic evaluations (psychologist/psychiatrist)—within the last three years
- Previous treatment reports, including hospital admission/discharge reports
- School records from most recent school placement
- IEP for applicants with special education needs

Please send the completed application and accompanying information by mail, fax or e-mail:

Three Springs - New Dominion Virginia
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