



Residential Treatment Programs Application for Admission

Date:

DEMOGRAPHIC INFORMATION

Full Name of Applicant:				
Address:				
City:	State:	Zip:		
DOB:	Sex	<input type="checkbox"/> male	<input type="checkbox"/> female	SS#:
Was the applicant adopted?	<input type="checkbox"/> yes	<input type="checkbox"/> no	If yes, at what age?	

PARENT/GUARDIAN INFORMATION

Mother/guardian name:	Does this person have custody of the applicant? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> 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:

<input type="checkbox"/> prescription medications	<input type="checkbox"/> alcohol
<input type="checkbox"/> cocaine	<input type="checkbox"/> heroin
<input type="checkbox"/> inhalants	<input type="checkbox"/> ecstasy
<input type="checkbox"/> methamphetamine	<input type="checkbox"/> marijuana
<input type="checkbox"/> other (please list)	

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	<input type="checkbox"/> hospitalization <input type="checkbox"/> out-patient <input type="checkbox"/> day treatment <input type="checkbox"/> under care of psychiatrist <input type="checkbox"/> under care of psychologist <input type="checkbox"/> substance abuse <input type="checkbox"/> other: _____

2) Facility:	Dates of treatment:
Name of treating professional:	
Type of Treatment	<input type="checkbox"/> hospitalization <input type="checkbox"/> out-patient <input type="checkbox"/> day treatment <input type="checkbox"/> under care of psychiatrist <input type="checkbox"/> under care of psychologist <input type="checkbox"/> substance abuse <input type="checkbox"/> other: _____

3) Facility:	Dates of treatment:
Name of treating professional:	
Type of Treatment	<input type="checkbox"/> hospitalization <input type="checkbox"/> out-patient <input type="checkbox"/> day treatment <input type="checkbox"/> under care of psychiatrist <input type="checkbox"/> under care of psychologist <input type="checkbox"/> substance abuse <input type="checkbox"/> other: _____

REFERRAL SOURCE

How did you find out about Three Springs?	
<input type="checkbox"/> Independent Educational Consultant	<input type="checkbox"/> Three Springs staff
<input type="checkbox"/> Another parent	<input type="checkbox"/> Publication
<input type="checkbox"/> Mental Health Professional	<input type="checkbox"/> Internet
<input type="checkbox"/> Other _____	
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 Paint Rock Valley
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