



**Three Springs Outdoor Therapeutic Program
168 Three Springs Rd.
Nunnely, TN 37137**

CLIENT/FAMILY HISTORY

YOUTH'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PARENTS/GUARDIANS: _____

DATE COMPLETED: _____

CLIENT/FAMILY HISTORY COMPLETED BY: _____

REFERRED TO THREE SPRINGS BY: _____

I. **PRESENTING ISSUES.**

1. What problems or issues led to your decision to admit your child to Three Springs?

2. Who referred you to this treatment facility and why?

3. What do you see as significant events that led up to or impacted on present problems?

4. What does your son do when he is upset or frustrated?

5. What is your son's most irritating behavior at home?

6. When your son acts up at home, how is he disciplined and by whom?

7. How does your son respond to discipline? _____

Presenting Issues (continued)

8. Please list any current and past legal charges against your son.

9. Is your son on probation for any of these legal charges? Please Explain.

10. Does your son accept responsibility for these charges?

11. What are your son's strengths?

12. What are your son's weaknesses?

13. Are you aware of any physical, emotional, sexual abuse or neglect that your son has experienced? yes no

Please explain.

Was it reported? yes no

To whom?

14. Please list your son's drug/alcohol use history (if any).

Substance	Age/Date of Onset	Frequency/Amount	Last Use	Type of Treatment
cigarettes				
marijuana				
alcohol				
ecstasy				
LSD				
crystal met				
cocaine				
stimulants				
prescription pill misuse (what kind?)				
other				

I. PREGNANCY AND BIRTH.

A. PRENATAL

1. Please describe any complications during pregnancy. _____

2. How did you feel emotionally about having or adopting your son?

3. How was the mother's health, if known, during pregnancy? _____
4. Did she experience any of the following?

SYMPTOMS	YES	NO	PLEASE EXPLAIN
German Measles			
Diabetes			
Influenza			
Tuberculosis			
Anemia			
Caffeine Intake			
Alcohol Intake			
Smoke Cigarettes			
Take Medications(s)			
Have Any Infections			
Emotional Upset			
Illegal Drug Use			
Other Toxic Drugs			
Toxemia			
Other Problems/Concerns During Pregnancy			

B. BIRTH

1. What was the birth weight of your son? _____
2. Was your son delivered vaginally or by cesarean section? _____
3. What were his APGAR scores? _____
4. Were there any complications or difficulties during your son's birth? _____
Please explain. _____
5. Were there any birth defects noted? _____
Please explain. _____

C. NEONATAL

1. Was your son breast or bottle fed? _____
2. When was your son weaned? _____
3. Was your son too active or not active enough? _____
4. Please describe any problems or developmental delays (if applicable). _____

5. Please list any childhood diseases during this age period and state any ongoing problems that resulted. _____

6. Please list any significant medications taken by your son during this time. _____

7. Please list any hospitalizations or ER visits and explain as applicable. _____

8. Please list any serious health problems not otherwise mentioned. _____

9. When was mother discharged from the hospital following giving birth? _____
10. When was your son discharged from the hospital following birth? _____

III. PRESCHOOL YEARS.

A. 0-3 YEARS

PHYSICAL ACTIVITY	AGE
sat without support	
cooed	
recognized parents, siblings, etc.	
stood along	
walked	
attempted to dress and undress self	
crawled	
said words	
smiled	
used sentences	
age toilet training began	
age toilet training complete	
other	

1. Was your son too active or not active enough? _____
2. Were there any problems or developmental delays? (Please explain if applicable). _____

Preschool Years (continued)

3. Please indicate your son’s general disposition up to age 3 with an “X” for behaviors which most frequently occurred.

- | | | | |
|-------|------------------------------------|-------|------------------------------------|
| _____ | feared abandonment | _____ | affectionate |
| _____ | quiet | _____ | withdrawn |
| _____ | active | _____ | frequently cried |
| _____ | irritable | _____ | feared adults |
| _____ | happy | _____ | required/sought constant attention |
| _____ | curious | _____ | generally aggressive |
| _____ | preferred to play with others | _____ | threw tantrums when angered |
| _____ | fearful of death | _____ | had difficulties with siblings |
| _____ | ate most foods readily | _____ | made friends easily |
| _____ | soiled clothing/wet bed | _____ | slept through the night |
| _____ | feared nighttime | _____ | cared for pets/animals |
| _____ | aggressive toward parents/siblings | _____ | shy |

4. Did your son have any of the following illnesses during this period (or up to age 3 years)? If so, please indicate age illness occurred, current status of illness and other pertinent details as applicable.

ILLNESS	YES	NO	AGE	PLEASE EXPLAIN
severe, recurrent headaches				
epilepsy, seizures and/or blackouts				
limited intelligence				
speech or hearing difficulties				
cancer				
diabetes				
thyroid disease				
lung problems, asthma, allergies				
other				
other				

5. Please list any childhood diseases during this age period and state any ongoing problems that resulted. _____

6. Please list any significant medications taken by your son during this time. _____

Preschool Years (continued)

7. Please list any accidents, unscheduled doctor visits, hospitalizations or ER visits and explain. _____

8. Please list any serious health problems not otherwise mentioned. _____

D. 4-6 YEARS (Daycare/Preschool Years)

PHYSICAL ACTIVITY	AGE
attempted to dress or undress self	
age toilet training began	
age toilet training complete	
no soiling accidents	
no wetting accidents	
other	

1. How active was your son? (Circle all that apply.)
 coordinated, uncoordinated, slow, sluggish, quiet, too active
2. Were there any problems or developmental delays? (Please explain if applicable.)

3. Did your son have any of the following illnesses? If so, please indicate age illness occurred, current status of illness and pertinent details.

ILLNESS	YES	NO	AGE	PLEASE EXPLAIN
high blood pressure				
severe, recurrent headaches				
epilepsy, seizures and/or blackouts				
limited intelligence				
speech or hearing difficulties				
cancer				
diabetes				
thyroid disease				
lung problems, asthma, allergies				
Other				

4-6 Years (continued)

- 4. Please list any childhood diseases during this age period and state any ongoing problems that resulted. _____

- 5. Please list any over the counter or prescription medications taken by your son during this time. _____

- 6. Please list any accidents, unscheduled doctor visits, hospitalizations or ER visits and explain as applicable. _____

- 7. Please list any serious health problems not otherwise mentioned. _____

- 8. What were your son's favorite activities? _____

- 9. What were your son's favorite toys? _____

- 10. How active was your son? (Circle all that apply.)
coordinated, uncoordinated, slow, sluggish, quiet, too active
- 11. Please indicate your son's general disposition from age 3 to age 6 with an "X" for behaviors which most frequently occurred.

- | | |
|--|--|
| _____ feared abandonment | _____ affectionate |
| _____ quiet | _____ withdrawn |
| _____ active | _____ frequently cried |
| _____ irritable | _____ feared adults |
| _____ happy | _____ required/sought constant attention |
| _____ curious | _____ generally aggressive |
| _____ preferred to play with others | _____ threw tantrums when angered |
| _____ feared death | _____ had difficulties with siblings |
| _____ ate most foods readily | _____ made friends easily |
| _____ soiled clothing/wet bed | _____ slept through the night |
| _____ feared nighttime | _____ cared for pets/animals |
| _____ aggressive toward parents/siblings | _____ shy |
| _____ shared | _____ preferred older friends |
| _____ preferred younger friends | _____ preferred same age friends |
| _____ preferred to play alone | _____ other _____ |

IV ELEMENTARY YEARS 7-12 YEARS, GRADES 1-6.

A. Behaviors at Home:

1. Did your son have any responsibilities or chores at home? yes no
How did he respond to these responsibilities? _____

2. Were there any behavioral problems at home? yes no
Please explain. _____

3. Did your son attempted to run away? yes no When? _____
age _____ length of time gone _____
4. Did your son experience any serious depressive episodes? yes no
Please explain. _____

5. Did your son make any suicidal verbalizations or gestures? yes no
When? Please explain. _____

6. Did your son have any problems sleeping or eating? yes no
Please explain. _____

7. Please indicate your son's general disposition from age 6 years to age 12 years with
an "X" for behaviors which most frequently occurred.

- | | |
|---|---|
| <input type="checkbox"/> feared abandonment | <input type="checkbox"/> affectionate |
| <input type="checkbox"/> quiet | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> active | <input type="checkbox"/> frequently cried |
| <input type="checkbox"/> irritable | <input type="checkbox"/> feared adults |
| <input type="checkbox"/> happy | <input type="checkbox"/> required/sought constant attention |
| <input type="checkbox"/> curious | <input type="checkbox"/> generally aggressive |
| <input type="checkbox"/> preferred to associate with others | <input type="checkbox"/> threw tantrums when angered |
| <input type="checkbox"/> feared death | <input type="checkbox"/> had difficulties with siblings |
| <input type="checkbox"/> ate most foods readily | <input type="checkbox"/> made friends easily |
| <input type="checkbox"/> soiled clothing/wet bed | <input type="checkbox"/> slept through the night |
| <input type="checkbox"/> feared nighttime | <input type="checkbox"/> cared for pets/animals |
| <input type="checkbox"/> aggressive toward parents/siblings | <input type="checkbox"/> shy |
| <input type="checkbox"/> shared | <input type="checkbox"/> preferred older friends |
| <input type="checkbox"/> preferred younger friends | <input type="checkbox"/> preferred same age friends |
| <input type="checkbox"/> preferred to play alone | <input type="checkbox"/> other _____ |

Elementary Years (continued)

8. Did your son have any of the following illnesses? If so, please indicate age illness occurred, current status of illness and pertinent details.

ILLNESS	YES	NO	AGE	PLEASE EXPLAIN
high blood pressure				
severe, recurrent headaches				
epilepsy, seizures and/or blackouts				
limited intelligence				
speech or hearing difficulties				
cancer				
diabetes				
thyroid disease				
lung problems, asthma, allergies				
health problems not otherwise mentioned				

9. Was your son prone to accidents? _____ yes _____ no Please explain. _____

10. Please list any hospitalizations, unscheduled doctor visits, or ER visits, and explain.

11. Did your son receive any recommendations or evaluations for treatment of emotional or behavioral problems? If yes, please indicate who, when, where and why.

12. Please describe any physical or medical disabilities that in any way restricted your son's activities. _____

Elementary Years (continued)

B. Behaviors at School

1. What was your son's attitude toward school? _____

2. Did your son have any school attendance problems? _____ yes _____ no
Please explain. _____

3. Did your son have any behavioral problems at school? _____ yes _____ no
How many suspensions? _____ How many detentions? _____
How many expulsions? _____
Please explain. _____

4. Did your son have any trouble with homework? _____ yes _____ no
Please explain. _____

C. Activities

1. What were your son's favorite activities? _____

2. Did your son participate in any organization activities? (sports, church, scouts, et cetera) _____

3. Please describe your son's friends (special friends, part of a group, loner, etc.) _____

4. Please describe any other special relationships such as with teachers, neighbors, etc.

V. JUNIOR/SENIOR HIGH SCHOOL, 13-17 YEARS, GRADES 7-12.

A. Behaviors at Home:

1. Has your son had have any responsibilities or chores at home? ____ yes ____ no
Please explain. _____

2. Has there been any behavioral problems at home? ____ yes ____ no
Please explain. _____

3. Has your son attempted to run away? ____ yes ____ no When? _____
age _____ length of time gone _____
4. Has your son experienced any serious depressive episodes? ____ yes ____ no
Please explain. _____

5. Has your son made any suicidal verbalizations or gestures? ____ yes ____ no
Please explain. _____

6. Has your son had any problems sleeping or eating? ____ yes ____ no
Please explain. _____

7. Please indicate your son's general disposition from age 12 years to age 18 years with an "X" for behaviors which most frequently occurred.

- | | |
|--|--|
| _____ feared abandonment | _____ affectionate |
| _____ quiet | _____ withdrawn |
| _____ active | _____ frequently cried |
| _____ irritable | _____ feared adults |
| _____ happy | _____ required/sought constant attention |
| _____ curious | _____ generally aggressive |
| _____ preferred to associate with others | _____ threw tantrums when angered |
| _____ feared death | _____ had difficulties with siblings |
| _____ ate most foods readily | _____ made friends easily |
| _____ soiled clothing/wet bed | _____ slept through the night |
| _____ feared nighttime | _____ cared for pets/animals |
| _____ aggressive toward parents/siblings | _____ shy |
| _____ shared | _____ preferred older friends |
| _____ preferred younger friends | _____ preferred same age friends |
| _____ preferred to play along | _____ other _____ |

Junior/Senior High (continued)

8. Has your son had any of the following illnesses? If so, please indicate age illness occurred, current status of illness and other pertinent details as applicable.

ILLNESS	YES	NO	AGE	PLEASE EXPLAIN
severe, recurrent headaches				
epilepsy, seizures and/or blackouts				
limited intelligence				
speech or hearing difficulties				
cancer				
diabetes				
thyroid disease				
lung problems, asthma, allergies				
other				

9. Please list any diseases during this age period and state any ongoing problems that resulted _____

10. Please list any accidents, unscheduled doctor visits, hospitalizations, or ER visits, and explain. _____

11. Please list any over the counter medications and/or prescription medications your son has taken during this time. _____

12. Please describe any physical or medical disabilities that has in any way restricted your son's activities. _____

B. Behaviors at School

1. What has been your son's attitude toward school? _____

2. Has your son had any school attendance problems? _____ yes _____ no
 Please explain. _____

Junior/Senior High (continued)

3. Has your son had any behavioral problems at school? _____ yes _____ no
How many suspensions? _____ How many detentions? _____
How many expulsions? _____
Please explain. _____

4. Has your son had any trouble with homework? _____ yes _____ no
Please explain. _____

C. Activities

1. What have been your son's favorite activities? _____

2. Has your son participated in any organized activities? (sports, church, scouts, etc.)

3. Please describe your son's friends (special friends, part of a group, loner, etc.) _____

4. Please describe any other special relationships such as with teachers, neighbors, etc.

5. Please describe any physical or medical disabilities that have in any way restricted your son's activities. _____

6. Is your son taking any over the counter or prescribed medications? ____ yes ____ no
Please describe when medication was begun, reason for medication, type, and dosage. _____

VI. SEXUAL DEVELOPMENT.

A. PUBERTY

1. Has your son entered puberty? ____ yes ____ no When? _____
2. Has your son verbalized any concerns or confusion about his sexual identity?
____ yes ____ no If yes, please explain. _____

3. Please list any significant events or relationships in your son's life including girlfriends or boyfriends. _____

4. Describe your son's interest in learning about sex, including age at which questions were asked, to whom, and how this was handled. _____

5. Is your son sexually active? _____
6. Is your son knowledgeable about birth control? _____
7. How did he get his information? _____
8. Comments: _____

VII. PEER RELATIONSHIPS.

A. FRIENDS

1. What age group does your son spend his free time with? _____
2. Have your son's friends had a positive or negative influence on him? _____
Please explain. _____

3. Have you approved of your son's peer friendships? _____
Please explain. _____

4. Has your son had a "best friend"? _____
Please explain. _____

VIII. CURRENT SCHOOL FUNCTIONING.

- A. What grade is your son currently in? _____
- B. Has your son failed any grades? _____
Please explain. _____

- C. Please list your son's current grades as well as grades he made two years prior to admittance to Three Springs.

CURRENT

Reading _____
English _____
Writing _____
Arithmetic or Math _____
Spelling _____

TWO YEARS AGO

Reading _____
English _____
Writing _____
Arithmetic or Math _____
Spelling _____

- D. What seems to be the center of your son's academic problems (if applicable)?

- E. Has your son had any restrictions or educational handicapping conditions (i.e. learning disabilities, physical, mental, or emotional disabilities)? _____
If yes, please explain. _____

- F. Has your son been referred or received special educational services? _____
If yes, what were the dates and outcomes of these referrals? _____

VIX. FAMILY DATA.

**A. Father, Adoptive Father, Other (i.e. male guardian, foster father) (Circle One)
(for stepfather, see page 20)**

1. What is your son's father's date of birth? _____
2. Where was you son's father born? _____
3. How much contact does he have with your son? _____
4. Is he very involved with your son? Please explain.

5. Where did your son's father go to school and what was the highest grade he completed?

6. What is your son's father's primary occupation?

7. How long has he worked for his current employer? _____
8. How long has he been employed in his current position? _____
9. What are your son's father's special interests, sports, or hobbies?

10. Are both of your son's paternal grandparents living? _____
11. Where are your son's paternal grandparents living?

12. Please list you son's paternal aunts and uncles, ages, and where they live. ____

13. Has your son's father or any member of his family had physical, mental, emotional, or substance abuse problems? If so, please explain.

Substance	Relationship to your son	Age/Date of Onset	Frequency/ Amount	Last Use	Type of Treatment
cigarettes					
marijuana					
alcohol					
ecstasy					
LSD					
crystal met					
cocaine					
stimulants					
prescription pills(what kind?)					
other					

**B. Mother, Adoptive Mother, Other (i.e. female guardian, foster mother) (Circle One)
(for stepmother, see page 19)**

1. What is her date of birth? _____
2. Where was she born? _____
3. How much contact does she have with your son? _____
4. Is she very involved with your son? Please explain. _____

5. Where did she go to school and what was the highest grade she completed? _____
6. What is her primary occupation? _____
7. How long has she worked for her current employer? _____
8. How long has she been employed in her current position? _____
9. What are her special interests, sports, hobbies? _____

10. Are both of her parents living? _____
11. Where are they living? _____

12. Please list your son's maternal aunts and uncles, ages, and where they live.

13. Has your son's mother or any member of her family had any physical, mental, emotional, or substance abuse problems? If so, please explain.

Substance	Relationship to your son	Age/Date of Onset	Frequency/ Amount	Last Use	Type of Treatment
cigarettes					
marijuana					
alcohol					
ecstasy					
LSD					
crystal met					
cocaine					
stimulants					
prescription pills(what kind?)					
other					

C. Stepmother (if applicable)

(Please have stepmother complete, if possible)

1. What is your son's stepmother's date of birth? _____
2. Where was she born? _____
3. How much contact does she have with your son? _____
4. Is she very involved with your son? Please explain. _____

5. Where did she go to school and what was the highest grade she completed?

6. What is her primary occupation? _____
7. How long has she worked for her current employer? _____
8. How long has she been employed in her current position? _____
9. What are her special interests, sports, hobbies?

10. Are both of her parents living? _____
11. Where are her parents living? _____
12. Please list her sisters and brothers, ages, and where they live.

13. Has she or any member of her family had any physical, mental, emotional, or substance abuse problems? If so, please explain. _____

Substance	Relationship to your son	Age/Date of Onset	Frequency/ Amount	Last Use	Type of Treatment
cigarettes					
marijuana					
alcohol					
ecstasy					
LSD					
crystal met					
cocaine					
stimulants					
prescription pills(what kind?)					
other					

D. Stepfather (if applicable)

(Please have stepfather complete, if possible)

1. What is your son's stepfather's date of birth? _____
2. Where was your son's stepfather born? _____
3. How much contact does he have with your son? _____
4. Is your son's stepfather very involved with your son? Please explain.

5. Where did your son's stepfather go to school and what was the highest grade he completed?

6. What is your son's stepfather's primary occupation?

7. How long has he worked for his current employer? _____
8. How long has he been employed in his current position? _____
9. What are your son's stepfather's special interests, sports, and hobbies?

10. Are both of your son's stepfather's parents living? _____
11. Where are your son's stepfather's parents living?

12. Please list your son's stepfather's sisters and brothers, ages, and where they live.

13. Has your son's stepfather or any member of his family had any physical, mental, emotional, or substance abuse problems? Please explain.

Substance	Relationship to your son	Age/Date of Onset	Frequency/ Amount	Last Use	Type of Treatment
cigarettes					
marijuana					
alcohol					
ecstasy					
LSD					
crystal met					
cocaine					
stimulants					
prescription pills(what kind?)					
other					

F. Family

1. Please describe current and previous marriages of either parent.

PARENT'S NAME	DATE MARRIED	RELATIONSHIP TO YOUR SON	DATE OF DIVORCE	NAME OF SPOUSE

2. Where has your son resided for the past 5 years?

ADDRESS (street, city, state)	HOW LONG DID HE LIVE AT THIS ADDRESS?	CARE GIVER

3. If either birth parent is not living with your son, where is she/he now and how much contact does she/he have with your son?

4. Please describe any areas of conflict in your marriage.

5. Please describe any losses of immediate family members or other relatives over the past 5 years by death, marriage, separation, or moving away.

G. Family Medical and Developmental History

1. Has any member of the family had any of the following illnesses? (If your son is adopted, please give information about both birth family and adopted family, if known.)

SYMPTOMS/DISEASE	YES	NO
High blood pressure		
Severe, recurrent headaches		
Epilepsy, seizures, blackouts		
Limited intelligence		
Learning difficulties		
Speech or hearing problems		
Cancer		
Diabetes		
Thyroid disease		
Lung problems, asthma, allergies		
Heart disease		
Liver, stomach, gall bladder problems		
Intestinal problems		
Kidney disease		
Reproductive organ disease		
Arthritis, bone, back disease		
Emotional illness		
Other		

2. If you answered "yes" to any of the above, please explain.

H. Family Psychiatric History.

Has anyone in your family ever had a diagnosis of the following?

DIAGNOSIS	YES	NO	RELATIONSHIP TO YOUR SON	WHO MADE THIS DIAGNOSIS?	TREATMENT (medication, hospitalization, outpatient care, etc.)
Depression					
Schizophrenia					
Bipolar Affective Disorder					
Cyclothymic Disorder					
Generalized Anxiety					
ADHD/ADD					
Learning Disorder (specify)					
Obsessive Compulsive Disorder					
Personality Disorder					
Asperger's Disorder					
Panic Disorder					
Tic Disorder					
Dissociative Disorder (multi-personality)					
Eating Disorder					
Intermittent Explosive Disorder					
Other					

I. Involvement in Treatment.

1. What would you like to see accomplished through treatment at Three Springs? _____

2. What are your feelings/attitude about your son being in residential treatment?

3. Are you willing to be involved in monthly family sessions at Three Springs?
_____ yes _____ no
4. Are you willing to be involved in monthly Family Day activities at Three Springs? _____ yes _____ no
5. Are you willing to correspond by mail with your son? _____ yes _____ no
6. Are you willing to supervise your son on therapeutic home visits? (Not applicable for LEAPS Program.) _____ yes _____ no
7. Are you available to supervise your son on therapeutic town and home visits? (Not applicable for LEAPS Program.) _____ yes _____ no
8. Are you currently seeing a family therapist? _____ yes _____ no
Who? (name, address, telephone number) _____

9. Are you willing to regularly be involved in outpatient family therapy in your community, in addition to family sessions conducted here, while your son is in treatment? _____ yes _____ no
10. Do you have any suggestions, comments, or concerns about our program at Three Springs? _____

Additional comments: