SUMMITSTONE
HEALTH PARTNERS

Client ID #: __________

Registration Form

Please provide the following information (or complete for the individual seeking services)

Personal Information **Today's Date: ____/____/____**

Last Name: _________________ **First Name: _________________** **Middle Name: _________________**

Alias: _________________

Client's Date of Birth: ______/______/______ **Social Security #: _____-_____-_____**

Gender Identity: ☐Female ☐Male ☐Genderqueer ☐Transgender(FTM) ☐Transgender(MTF) ☐Other

Mailing Address: ____________________________ **City: ____________________** **State:_______** **Zip: _______**

County: ____________________________ **May we mail letters to you:** ☐ **yes** ☐ **no**

Physical Address: __________________________ **City:____________________** **State:_______** **Zip: _______**

County: ____________________________

Phone #: (_____) **______________________** ☐ home ☐ cell ☐ work Are voice messages ok?: ☐ yes ☐ no

Are text messages ok?: ☐ yes ☐ no

Other #: (_____) **______________________** ☐ home ☐cell ☐work Are voice messages ok?: ☐ yes ☐ no

Are text messages ok?: ☐ yes ☐ no

Communication Preference:

☐Email ☐Regular Mail ☐Home Phone ☐Work Phone ☐Cell Phone ☐ Do not contact

Marital Status: ☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Widowed

Residency Status: ☐ Under 18 ☐ Lawfully present in the U.S. ☐ Permanent Resident ☐ U. S. Citizen
☐ None of these

Race: *(check all that apply)* ☐ Hispanic/Latino ☐ American Indian/Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other: __________

Ethnic Origin: ☐ Hispanic Cuban ☐ Hispanic Mexican ☐ Hispanic Puerto Rican ☐ Hispanic Other
☐ Not Hispanic

Primary Language: ____________________________________

Current Living Arrangements: *(check all that apply)* ☐ Alone ☐ Mother ☐ Father ☐ Siblings ☐ Relatives(kin)
☐ Foster Parents ☐ Guardian ☐ Spouse ☐ Partner/Significant Other ☐ Children ☐ Unrelated
Person(s) ☐ Homeless ☐ Dependent living in a supervised setting ☐ Dependent living with Parents

Employment Status: ☐Part time ☐ Full time ☐ Disabled ☐ Student ☐ Homemaker ☐ Inmate
☐Military ☐ Retired ☐ Unemployed

Veteran of the United States Military? ☐ Yes ☐ No **Branch _________________**

Religion: ____ **or** ☐ I choose not to disclose

Smoking Status: ☐Never Smoked ☐ Former Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker

# of Years of Education completed (including grade school): ______

Degree received: ☐ HS Diploma/GED ☐ Some college ☐ Associates/Bachelors ☐ Masters ☐ Doctoral

Emergency Contact: ________________________ **Relationship:** ______________ **Phone #: (____)**________

<u>Parent/Guardian Information:</u> *(only complete if the above client is a dependent or under the age of 18)*

Last Name: __________________ **First Name:** __________________ **Social Security #:** ______-_____-_____

Address: ____________________________________**City:** ____________________**State:**_______ **Zip:** ________

Phone #: (_____) ______________ ☐ home ☐ cell ☐ work Are messages ok: ☐ yes ☐ no

Are text messages ok?: ☐ yes ☐ no

What is your relationship to the client? ☐ Father ☐ Guardian ☐ Mother

☐ Other (please specify): _______________ **Does SummitStone have a copy of proof of custody?** ☐ yes ☐ no

<u>Treatment Information</u>

Please check all that describe your current needs:

☐Crisis help ☐ Mental health services ☐ Addiction recovery services

☐Employment services ☐ Finding community resources

Did anyone refer you to treatment? ☐ Yes ☐ No If so, who? ____

Are you in need of a court-ordered treatment or assessment? ☐ Yes ☐ No

If yes, check all of the following that apply: ☐ Mental Health Assessment ☐ Drug/Alcohol Assessment

☐ Anger Management ☐Other: ________________________

Please check all that apply to your current situation:

☐ I feel threatened by someone/something

☐ I have thoughts of hurting myself

☐ I have thoughts of hurting others

☐ Legal issues: # of arrests in last 30 days: __________ # of DUI arrests in last 30 days: ____________

Symptom Checklist

Check off current symptoms or symptoms experienced in the past 2 weeks

Anxiety

- ☐ Agitation
- ☐ Fatigue
- ☐ Poor Concentration
- ☐ Sleep Disturbance
- ☐ Dissociative Episodes
- ☐ Excessive Worry
- ☐ Irritability
- ☐ Restlessness
- ☐ Tension
- ☐ Phobia

Delusions

- ☐ Grandiose
- ☐ Somatic
- ☐ Religious
- ☐ Persecution
- ☐ Paranoia
- ☐ Self-Deprecating

Hallucinations

- ☐ Auditory
- ☐ Smell
- ☐ Touch
- ☐ Visual

Depression

- ☐ Changes in Sleep
- ☐ Changes in Appetite
- ☐ Psychomotor Retardation
- ☐ Fatigue
- ☐ Hopelessness
- ☐ Changes in Weight
- ☐ Suicidal Ideations
- ☐ Agitation
- ☐ Diminished Self-Esteem
- ☐ Feeling sad or down most days
- ☐ Not enjoying the things you used to
- ☐ Excessive Guilt

Panic

- ☐ Heart Palpitations
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Hot Flashes
- ☐ Shortness of Breath
- ☐ Nausea
- ☐ Chills

Mania

- ☐ Grandiosity
- ☐ Pressured Speech
- ☐ Increased Activity
- ☐ Euphoria
- ☐ High Risk Behaviors
- ☐ Decreased Sleep
- ☐ Racing Thoughts
- ☐ Irritability
- ☐ Impulsivity

Behavior/Impulse

- ☐ Physical Aggression
- ☐ Pulling Hair Out
- ☐ Verbal Aggression
- ☐ Aggressive Impulses
- ☐ Excessive Spending
- ☐ Self-Injurious Behavior
- ☐ Attachment Issues
- ☐ Rageful Episodes
- ☐ Legal Problems
- ☐ Hostility
- ☐ Sexually Assaultive
- ☐ Suicidal Gestures
- ☐ Damage to Property
- ☐ Stealing
- ☐ Fire Setting
- ☐ Defiant
- ☐ Enuresis
- ☐ Domestic Violence
- ☐ Maladaptive Gambling
- ☐ Unruly
- ☐ Drug/Alcohol Abuse
- ☐ Impulsivity
- ☐ Encopresis
- ☐ Assaultive Behavior

Abuse / Trauma

- ☐ Avoid Stimuli associated with Trauma
- ☐ Hyper-arousal
- ☐ Flashbacks

Learning / Attention

- ☐ Difficulty Writing
- ☐ Difficulty Reading
- ☐ Difficulty with Mathematics
- ☐ Difficulty with Verbal Expression
- ☐ Developmental Delays
- ☐ Developmental Disability
- ☐ Hyperactivity
- ☐ Poor Attention
- ☐ Truancy
- ☐ Dyslexia
- ☐ Difficulty with Recognizing Letters

Eating

- ☐ Intense Fear of Gaining Weight
- ☐ Distored Body Image
- ☐ Absence of Menstruation
- ☐ Binge Eating
- ☐ Induced Vomiting
- ☐ Laxative Abuse
- ☐ Diuretic Abuse
- ☐ Excessive Exercise
- ☐ Fasting
- ☐ Compulsive Overeating
- ☐ Weight Gain
- ☐ Weight Loss

Assessment

Have you used Drugs or Alcohol Today?

☐ Yes ☐ No

Are you using substances and have dependent children?

☐ Yes ☐ No

Are you on an involuntary commitment for substance use?

☐ Yes ☐ No

Do you have a history of IV Drug Use?

☐ Yes ☐ No

Please answer the following if you are 19 or older

CAGE Assessment

Have you ever felt you should cut down on your drinking or drug use?

☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use?

☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use?

☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

☐ Yes ☐ No

Please complete this CRAFFT Assessment if you are 18 or younger

CRAFFT Assessment

Have you ever ridden in a CAR driven by someone; include you who was high/drunk or using?

☐ Yes ☐ No

Do you ever FORGET things you did while using alcohol or drugs?

☐ Yes ☐ No

Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

☐ Yes ☐ No

Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

☐ Yes ☐ No

Do you ever use drugs / alcohol while you are ALONE?

☐ Yes ☐ No

Have you ever gotten into TROUBLE while you were using drugs or alcohol?

☐ Yes ☐ No

Medical Information

Height ______________ **Weight** ______________

Are you currently pregnant?

☐ Yes ☐ No

Primary Care Physician ________________________ **Phone Number:** __________________________

Address: ____

Date of last visit: ______________

Reason for last visit: ____

Current physical / dental conditions/ problems:

____

____

____

Family History – has client or any blood relative suffered from any of the following:

Cancer
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Heart Disease / Stroke
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Diabetes
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Thyroid Trouble
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Other Hormonal Illness
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

History of Head Injuries
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Neurological Disease
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Epilepsy / Seizures
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Suicide / Suicide Attempts
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Anxiety
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Paranoia / Psychosis
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Schizophrenia
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Bi-Polar Depression
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Depression
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Alcoholism
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Drug Addiction
☐ Client ☐ Mother ☐ Father
☐ Siblings ☐ Grandparent ☐ Aunt/Uncle

Do you have an Advance Directive (living will/medical durable power of attorney)? ☐ Yes ☐ No

Will you authorize (sign a release of information) communication with your primary care provider?
☐ Yes ☐ No

Are you taking any of the following?

- ☐ Prescriptions
- ☐ Diet Aids
- ☐ Caffeine
- ☐ Over the Counter Medications
- ☐ Herbs or Supplements
- ☐ Tobacco Use
- ☐ None

Current Medications

- ☐ Abilify
- ☐ Lamictal
- ☐ Zoloft
- ☐ Seroquel
- ☐ Clonazepam
- ☐ None
- ☐ Trazodone
- ☐ Lamotrigine
- ☐ Concerta
- ☐ Lithium Carbonate
- ☐ Clozapine
- ☐

Other Current Medications

____

____

Current Non-Medication Allergies (mark all that apply)

- ☐ Seasonal Allergies
- ☐ Shellfish
- ☐ Bee Stings
- ☐ Mold
- ☐ Gluten
- ☐ Latex
- ☐ Pollen
- ☐ Grasses
- ☐ Nuts
- ☐ Cats

Other Current Non-Medication Allergies

____

____

Check All Allergies to Medication

- ☐ Penicillin
- ☐ Aspirin
- ☐ Vicodin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Wellburtin
- ☐ Morphine
- ☐ Lamictal
- ☐ Amoxicillin
- ☐ Haldol

Other Allergies to Medication

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____