SUMMITSTONE HEALTH PARTNERS

REGISTRATION FORM

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

Client ID: _____ **Today's Date:** ____/____/____

Personal Information

Last Name: _____ First Name: _____ Middle Name: _____

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Lesbian/Gay/Homosexual
☐ Other ☐ Unknown ☐ I choose not to disclose

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Non-Binary

Are you pregnant? Yes ☐ No ☐

Preferred Name: _____

Client's Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Contact Information

Mailing Address: _____ City: _____ State:_____ Zip: _____

County: _____ May we mail letters to you: ☐ Yes ☐ No

Physical Address: _____ City:_____ State:_____ Zip: _____

County: _____

Phone Number: _____	☐ Home ☐ Cell ☐ Work		
Are voice messages okay?	☐ Yes ☐ No	Are text messages okay?	☐ Yes ☐ No
Phone Number: _____	☐ Home ☐ Cell ☐ Work		
Are voice messages okay?	☐ Yes ☐ No	Are text messages okay?	☐ Yes ☐ No

Communication Preference:

☐ Email ☐ Regular Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Do Not Contact

Primary Language:

☐ English ☐ Spanish ☐ Other: _____

Ethnicity:

☐ Not Hispanic ☐ Hispanic Mexican ☐ Hispanic Cuban ☐ Hispanic Puerto Rican ☐ Hispanic Other

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Race (check all that apply):

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other: _____

Highest Level of Education Completed:

Highest Grade Completed _____ ☐ High School Diploma/GED ☐ Some College
☐ Associates/Bachelors ☐ Masters ☐ Doctoral

Employment Status:

☐ Part-time ☐ Full-time ☐ Disabled ☐ Student ☐ Homemaker ☐ Inmate ☐ Military ☐ Retired ☐ Unemployed

Marital Status:

☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed

Residency Status:

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

Religion: _____ **OR** ☐ I choose not to disclose

Smoking Status:

☐ Never Smoked ☐ Former Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker

Primary Care Physician Location (Name of Clinic):

Current Living Arrangement (check all that apply):

☐Alone
☐Mother
☐Father
☐ Siblings
☐ Spouse
☐ Foster Parents
☐ Partner/Significant Other
☐ Children
☐ Unrelated Person(s)
☐ Relatives (kin)
☐ Guardian
☐ Homeless
☐ Dependent living in supervised setting
☐ Dependent living with parents

Veteran Status:

☐ Not a Veteran ☐ Veteran Branch: _____

Dates of Military Service:

From _____ to _____

Emergency Contact: _____ **Relationship:** _____ **Phone Number: (____)** _____

Does the Emergency Contact Live with the Client? ☐ Yes ☐ No

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Parent/Guardian #1 Information: *(only complete if the above client is a dependent or under the age of 18)*

Last Name: _____ First Name: _____ Social Security Number: _____-_____-_____

Address: _____City: _____ State:_____ Zip: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work	
Are voice messages okay? ☐ Yes ☐ No	Are text messages okay? ☐ Yes ☐ No

Relationship to the Client:

☐ Father ☐ Mother ☐ Guardian ☐ Other: _____

Parent/Guardian #2 Information: *(only complete if the above client is a dependent or under the age of 18)*

Last Name: _____ First Name: _____ Social Security Number: _____-_____-_____

Address: _____City: _____ State:_____ Zip: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work	
Are voice messages okay? ☐ Yes ☐ No	Are text messages okay? ☐ Yes ☐ No

Relationship to the Client:

☐ Father ☐ Mother ☐ Guardian ☐ Other: _____

Does SummitStone have a copy of proof of custody (if applicable)? ☐ Yes ☐ No

TREATMENT INFORMATION

Please check all that describe your current needs:

☐ Crisis services
☐ Mental health services
☐ Addiction recovery services
☐ Employment services
☐ Finding community resources
☐ Other

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
☐ Anger Management
☐ Drug/Alcohol Assessment
☐ 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: Number of arrests in last 30 days: _____ Number of DUI arrests in last 30 days: _____

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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
- ☐ Religious
- ☐ Paranoia
- ☐ Somatic
- ☐ Persecution
- ☐ 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

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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, including 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

Primary Care Physician _____ **Phone Number:** _____

Address: _____

Date of last visit: _____ **Reason for last visit:**

Height _____ **Weight** _____

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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

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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 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
- ☐ Wellbutrin
- ☐ Morphine
- ☐ Lamictal
- ☐ Amoxicillin
- ☐ Haldol

Other Allergies to Medication:
