

SUMMITSTONE REGISTRATION – MINOR FORM (0-17 YEARS OF AGE)

Please provide the following information or complete for the person seeking services

CLIENT ID NUMBER:	TODAY'S DATE:
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PERSONAL INFORMATION

LAST NAME:	MIDDLE NAME:	FIRST NAME:	
SEXUAL ORIENTATION:	<input type="checkbox"/> STRAIGHT/HETEROSEXUAL	<input type="checkbox"/> BISEXUAL	<input type="checkbox"/> OTHER
	<input type="checkbox"/> LESBIAN/GAY/HOMOSEXUAL	<input type="checkbox"/> PANSEXUAL	<input type="checkbox"/> NOT DISCLOSING OR N/A
GENDER IDENTITY:	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE	<input type="checkbox"/> NON-BINARY
	<input type="checkbox"/> TRANSGENDER (MTF)	<input type="checkbox"/> TRANSGENDER (FTM)	<input type="checkbox"/> GENDERQUEER
ARE YOU PREGNANT	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNSURE
PREFERRED NAME:			
CLIENT'S DATE OF BIRTH:	SOCIAL SECURITY NUMBER (leave blank if you don't have one)		

CONTACT INFORMATION

MAILING ADDRESS:	CITY:	STATE:	ZIP:
COUNTY:	MAY WE MAIL LETTERS TO YOU?		<input type="checkbox"/> YES <input type="checkbox"/> NO
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP:
COUNTY:			

PLEASE PROVIDE AT LEAST ONE METHOD OF CONTACT

PHONE NUMBER:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL PHONE	<input type="checkbox"/> WORK
ARE VOICE MESSAGES OKAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE TEXT MESSAGES OKAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
PHONE NUMBER:	<input type="checkbox"/> HOME		
ARE VOICE MESSAGES OKAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARE TEXT MESSAGES OKAY?	<input type="checkbox"/> YES <input type="checkbox"/> NO

COMMUNICATION PREFERENCE

<input type="checkbox"/> Email	<input type="checkbox"/> Regular Mail	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	<input type="checkbox"/> Do Not Contact
EMAIL ADDRESS:					
PRIMARY LANGUAGE:					

ETHNICITY (USED FOR DEMOGRAPHIC DATA)

<input type="checkbox"/> Not Hispanic	<input type="checkbox"/> Hispanic Mexican	<input type="checkbox"/> Hispanic Cuban	<input type="checkbox"/> Hispanic Puerto Rican	<input type="checkbox"/> Other
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RACE (CHECK ALL THAT APPLY)

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Pacific Islander
<input type="checkbox"/> MENA: Middle Eastern/North African	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> South Asian	<input type="checkbox"/> Other

CURRENT GRADE OR N/A

CURRENT GRADE:	<input type="checkbox"/> NOT APPLICABLE
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EMPLOYMENT STATUS

<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student
<input type="checkbox"/> Homemaker	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Military	<input type="checkbox"/> Retired
<input type="checkbox"/> Inmate			

MARITAL STATUS

<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Never Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated
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SMOKING STATUS

<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Heavy Tobacco Smoker	<input type="checkbox"/> Light Tobacco Smoker
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CURRENT LIVING ARRANGEMENT (CHECK ALL THAT APPLY)

<input type="checkbox"/> Alone	<input type="checkbox"/> Foster Parents	<input type="checkbox"/> Guardian
<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Spouse
<input type="checkbox"/> Sibling(s)	<input type="checkbox"/> Partner/Significant Other	<input type="checkbox"/> Homeless
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Unrelated Person(s)	<input type="checkbox"/> Dependent living in supervised setting
<input type="checkbox"/> Dependent living with parents	<input type="checkbox"/> Relatives (kin)	

EMERGENCY CONTACT

Contact Name:	Relationship:	Phone Number:
Does the Emergency Contact live with the client? <input type="checkbox"/> YES <input type="checkbox"/> NO		

PARENT/GUARDIAN INFORMATION - NUMBER ONE

Last Name:	First Name:	Social Security:
Address		
City:	State:	Zip:
PHONE NUMBER:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL PHONE <input type="checkbox"/> WORK
ARE VOICE MESSAGES OKAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE TEXT MESSAGES OKAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to the client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other

PARENT/GUARDIAN INFORMATION - NUMBER TWO

Last Name:	First Name:	Social Security:
Address		
City:	State:	Zip:
PHONE NUMBER:	<input type="checkbox"/> HOME	<input type="checkbox"/> CELL PHONE <input type="checkbox"/> WORK
ARE VOICE MESSAGES OKAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE TEXT MESSAGES OKAY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to the client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other

Has a legal document providing Medical-Decision-Making information been provided to SummitStone?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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TREATMENT INFORMATION (THIS INFORMATION IS ONLY USED TO ASSURE APPROPRIATE TREATMENT)

PLEASE CHECK ALL THAT DESCRIBE YOUR NEEDS

<input type="checkbox"/> Crisis services	<input type="checkbox"/> Mental health services	<input type="checkbox"/> Addiction recovery services
<input type="checkbox"/> Employment services	<input type="checkbox"/> Finding community resources	<input type="checkbox"/> Other
<input type="checkbox"/> NONE		

Were you referred to treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, BY WHOM?
Are you in need of a court-ordered treatment or assessment? If yes, check all that apply. <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Mental Health Assessment	<input type="checkbox"/> Drug/Alcohol Assessment
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Other

PLEASE CHECK ALL THAT APPLY TO YOUR CURRENT SITUATION

<input type="checkbox"/> I feel threatened by someone/something	<input type="checkbox"/> I have thoughts of hurting myself
<input type="checkbox"/> I have thoughts of hurting others	<input type="checkbox"/> Legal issues: Number of arrests in last 30 days: Number of DUI arrests in last 30 days:
<input type="checkbox"/> NONE	