



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

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

DEMOGRAPHICS

Name:		
Preferred Name:		
Title:	First Name:	Middle Name:
Last Name: _____	Suffix: _____	Academic: Current Grade: _____ <input type="checkbox"/> Non-applicable
Confidential Name: _____	Preference Type: _____	

Social Security Number:		Date of Birth:
Legal Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> X	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Genderqueer <input type="checkbox"/> Non-Binary <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other	Sex assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Not recorded on Birth Certificate <input type="checkbox"/> Uncertain
Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Asexual		

Permanent: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Confidential		
Address:	City:	State:
Zip:	County:	Country:
Home Phone:	Work Phone:	Mobile Phone:
Email Address:		

ADDITIONAL DEMOGRAPHICS

<p>Permanent Comments</p>

ADDITIONAL PATIENT INFORMATION

Additional Demographic Info

<p>Phonetic Name: (<i>The way a spoken word sounds e.g. Jane Lily phonetically spelled is Jane Ligh-lee</i>)</p> <hr/>	<p>Relationship Status:</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Legally Separated</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Significant Other</p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Un-married Partner</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Widowed</p>
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Preferred Language:				
<input type="checkbox"/> Acholi	<input type="checkbox"/> Croatian	<input type="checkbox"/> Karenni	<input type="checkbox"/> Pashai	<input type="checkbox"/> Tigrinya
<input type="checkbox"/> Afar	<input type="checkbox"/> Czech	<input type="checkbox"/> Kayah	<input type="checkbox"/> Pashto	<input type="checkbox"/> Tongan
<input type="checkbox"/> Afrikaans	<input type="checkbox"/> Dari	<input type="checkbox"/> Kekchi (Q'eqchi)	<input type="checkbox"/> Patwa	<input type="checkbox"/> Trukese
<input type="checkbox"/> Akan (Twi)	<input type="checkbox"/> Dinka	<input type="checkbox"/> Kinyarwanda	<input type="checkbox"/> Persian	<input type="checkbox"/> Tshiluba
<input type="checkbox"/> Albanian	<input type="checkbox"/> Dutch	<input type="checkbox"/> Kirundi	<input type="checkbox"/> Pohnpeian	<input type="checkbox"/> Turkish
<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Ebon	<input type="checkbox"/> Kiswahilli	<input type="checkbox"/> Polish	<input type="checkbox"/> Twi
<input type="checkbox"/> Amharic	<input type="checkbox"/> Egyptian	<input type="checkbox"/> Korean	<input type="checkbox"/> Portuguese (Brazilian)	<input type="checkbox"/> Ukranian
<input type="checkbox"/> Arabic	<input type="checkbox"/> English	<input type="checkbox"/> Kuama	<input type="checkbox"/> Portuguese (European)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Arabic - Egyptian	<input type="checkbox"/> Eschira	<input type="checkbox"/> Kurdish	<input type="checkbox"/> Pulaar	<input type="checkbox"/> Urdu
<input type="checkbox"/> Arabic - Jordanian	<input type="checkbox"/> Ewe	<input type="checkbox"/> Lao (Laotian)	<input type="checkbox"/> Punjabi	<input type="checkbox"/> Uzbek
<input type="checkbox"/> Arabic - Moroccan	<input type="checkbox"/> Faroese	<input type="checkbox"/> Lingala	<input type="checkbox"/> Quechua	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Arabic - Sudanese	<input type="checkbox"/> Farsi (Persian)	<input type="checkbox"/> Lithuanian	<input type="checkbox"/> Quonjabal	<input type="checkbox"/> Visayan
<input type="checkbox"/> Aramaic	<input type="checkbox"/> Filipino	<input type="checkbox"/> Luba-Kasai	<input type="checkbox"/> Rohingya	<input type="checkbox"/> Wolof
<input type="checkbox"/> Armenian	<input type="checkbox"/> Finnish	<input type="checkbox"/> Malagasy	<input type="checkbox"/> Romani	<input type="checkbox"/> Yiddish
<input type="checkbox"/> Asante (Ahsanti) (Twi)	<input type="checkbox"/> Fon	<input type="checkbox"/> Malay	<input type="checkbox"/> Romanian	<input type="checkbox"/> Yoruba

<input type="checkbox"/> Assyrian	<input type="checkbox"/> French	<input type="checkbox"/> Malayalam	<input type="checkbox"/> Rotana
<input type="checkbox"/> Bahasa (Indonesia)	<input type="checkbox"/> Fula (Fulani)	<input type="checkbox"/> Maltese	<input type="checkbox"/> Russian
<input type="checkbox"/> Bambara	<input type="checkbox"/> Garifuna	<input type="checkbox"/> Mam	<input type="checkbox"/> Sami
<input type="checkbox"/> Bandu	<input type="checkbox"/> German	<input type="checkbox"/> Mandarin Chinese	<input type="checkbox"/> Samoan
<input type="checkbox"/> Bantu	<input type="checkbox"/> Greek	<input type="checkbox"/> Mandingo	<input type="checkbox"/> Sangho
<input type="checkbox"/> Bengali	<input type="checkbox"/> Greenlandic (Kalaallisut)	<input type="checkbox"/> Mandinka	<input type="checkbox"/> Serbian
<input type="checkbox"/> Berber	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Marathi	<input type="checkbox"/> Somali
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Hahka-Chin	<input type="checkbox"/> Marshallese	<input type="checkbox"/> Spanish
<input type="checkbox"/> Buldarian	<input type="checkbox"/> Hataian Creole	<input type="checkbox"/> Masalit	<input type="checkbox"/> Spanish and Sign Lang
<input type="checkbox"/> Burmese	<input type="checkbox"/> Hausa	<input type="checkbox"/> Miabei	<input type="checkbox"/> Sudanese
<input type="checkbox"/> Cambodian (Khmer)	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Moldovian	<input type="checkbox"/> Swahili
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Hebrew	<input type="checkbox"/> Mongolian	<input type="checkbox"/> Swedish
<input type="checkbox"/> Carolinian	<input type="checkbox"/> Hindi	<input type="checkbox"/> Moroccan Arabic (Darija)	<input type="checkbox"/> Tabasaran
<input type="checkbox"/> Catalan	<input type="checkbox"/> Hmong	<input type="checkbox"/> Nauran	<input type="checkbox"/> Tagalong
<input type="checkbox"/> Chaldean	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Navajo	<input type="checkbox"/> Taiwanese
<input type="checkbox"/> Chavacano	<input type="checkbox"/> Igbo	<input type="checkbox"/> Nepali (Nepalese)	<input type="checkbox"/> Tajik
<input type="checkbox"/> Chinese - Mandarin	<input type="checkbox"/> Italian	<input type="checkbox"/> Nigerian	<input type="checkbox"/> Tamil
<input type="checkbox"/> Chinese - Other	<input type="checkbox"/> Jamaican Creole	<input type="checkbox"/> Norwegian	<input type="checkbox"/> Telugu
<input type="checkbox"/> Chinese - Taiwanese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Oromo	<input type="checkbox"/> Thai
<input type="checkbox"/> Chinese - Cantonese	<input type="checkbox"/> K'iche (Quiche')	<input type="checkbox"/> Other	<input type="checkbox"/> Tibetan
<input type="checkbox"/> Chuukese (Trukese)	<input type="checkbox"/> Karen	<input type="checkbox"/> Palauan	<input type="checkbox"/> Tigre

<p>Needs Interpreter:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Race:</p> <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other Asian <input type="checkbox"/> Patient Declined <input type="checkbox"/> Unknown <input type="checkbox"/> More than one race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<p>Ethnicity:</p> <input type="checkbox"/> Non-Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Unknown <input type="checkbox"/> Patient unable to Answer
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	<input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan																																																							
Ethnic Background: <input type="checkbox"/> Mexican, Mexican-American, or Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic/Latino/am or Spanish Origin <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Patient Unable to Answer <input type="checkbox"/> Non-Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Ashkenazi	Religion: <table border="1" data-bbox="574 457 1469 1709"> <tr> <td><input type="checkbox"/> Agnostic</td> <td><input type="checkbox"/> Nazarine</td> </tr> <tr> <td><input type="checkbox"/> Anglican</td> <td><input type="checkbox"/> No Religious Preference</td> </tr> <tr> <td><input type="checkbox"/> Assembly of God</td> <td><input type="checkbox"/> Non-Denominational</td> </tr> <tr> <td><input type="checkbox"/> Atheist</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Baha'i</td> <td><input type="checkbox"/> Not Religious</td> </tr> <tr> <td><input type="checkbox"/> Baptist</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Buddhist</td> <td><input type="checkbox"/> Pagan</td> </tr> <tr> <td><input type="checkbox"/> Catholic</td> <td><input type="checkbox"/> Patient Declined</td> </tr> <tr> <td><input type="checkbox"/> Christian</td> <td><input type="checkbox"/> Pentecostal</td> </tr> <tr> <td><input type="checkbox"/> Christian Reformed</td> <td><input type="checkbox"/> Presbyterian</td> </tr> <tr> <td><input type="checkbox"/> Christian Scientist</td> <td><input type="checkbox"/> Protestant</td> </tr> <tr> <td><input type="checkbox"/> Church of Crist</td> <td><input type="checkbox"/> Quaker</td> </tr> <tr> <td><input type="checkbox"/> Church of Jesus Christ of Latter-day Saints</td> <td><input type="checkbox"/> Reformed Church of America</td> </tr> <tr> <td><input type="checkbox"/> Eastern Orthodox</td> <td><input type="checkbox"/> Russian Orthodox</td> </tr> <tr> <td><input type="checkbox"/> Episcopalian</td> <td><input type="checkbox"/> Scientologist</td> </tr> <tr> <td><input type="checkbox"/> Greek Orthodox</td> <td><input type="checkbox"/> Seventh Day Adventist</td> </tr> <tr> <td><input type="checkbox"/> Hare Krishna</td> <td><input type="checkbox"/> Shinto</td> </tr> <tr> <td><input type="checkbox"/> Hindu</td> <td><input type="checkbox"/> Sikh</td> </tr> <tr> <td><input type="checkbox"/> Humanism</td> <td><input type="checkbox"/> Taoist</td> </tr> <tr> <td><input type="checkbox"/> Jain</td> <td><input type="checkbox"/> Unitarian Universalist</td> </tr> <tr> <td><input type="checkbox"/> Jehovah's Witness</td> <td><input type="checkbox"/> United Church of Christ</td> </tr> <tr> <td><input type="checkbox"/> Jewish</td> <td><input type="checkbox"/> Unity Church</td> </tr> <tr> <td><input type="checkbox"/> Lutheran</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Menonite</td> <td><input 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<input type="checkbox"/> Methodist	<input type="checkbox"/> Zoroastrian																																																							
<input type="checkbox"/> Muslim																																																								

Homeless Status: <input type="checkbox"/> Yes <input type="checkbox"/> No	Homeless Type: <input type="checkbox"/> Doubling Up <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Not Homeless <input type="checkbox"/> Other <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown	Public Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No
Agricultural Worker Status: <input type="checkbox"/> Migratory (<i>Individuals who are 'mobile workers' or' migratory agricultural workers'</i>) <input type="checkbox"/> Neither <input type="checkbox"/> Seasonal (<i>Individuals who are employed temporary framework, but do not move from their permanent residence to seek farmwork</i>)	Currently Serving: <input type="checkbox"/> Active Duty <input type="checkbox"/> Never Served <input type="checkbox"/> No <input type="checkbox"/> Other Reserve/National Guard <input type="checkbox"/> Veteran	Branch of Service: <input type="checkbox"/> Air Force <input type="checkbox"/> Various <input type="checkbox"/> Army Branches <input type="checkbox"/> Cost Guard <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy
Veteran Status: <input type="checkbox"/> Combat Veteran <input type="checkbox"/> No, Never Served <input type="checkbox"/> Non-combat Veteran Dates of Military Service - from _____ to _____		
Employment Status: <input type="checkbox"/> Active – Leave of Absence <input type="checkbox"/> Active <input type="checkbox"/> Full Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Student – Part Time <input type="checkbox"/> Student – Full Time <input type="checkbox"/> Terminated <input type="checkbox"/> Unknown		

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 (SELECT 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)	<input type="checkbox"/> Other

ACCESSIBILITY AND DISABILITY

<p>Disability Needs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Blind <input type="checkbox"/> Cognitive/Intellectual/Learning <input type="checkbox"/> Deaf/Does not use Sign Language <input type="checkbox"/> Deaf/Uses Sign Language <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Hearing loss/Hard of Hearing <input type="checkbox"/> Low Vision <input type="checkbox"/> Manual Dexterity Disability <input type="checkbox"/> Mobility Disability <input type="checkbox"/> None <input type="checkbox"/> Other Disability Requiring Accommodation <input type="checkbox"/> Speech/Communication Disability 	<p>Disability Accommodation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accessible Medical Equipment <input type="checkbox"/> Alternate Call Button <input type="checkbox"/> Alternate Format Documents <input type="checkbox"/> Assistance with Forms <input type="checkbox"/> Assistive Listening Devices <input type="checkbox"/> Assistive Listening Devices <input type="checkbox"/> Support Person <input type="checkbox"/> Clear Mask <input type="checkbox"/> Communication Board <input type="checkbox"/> Extended Appt Time <input type="checkbox"/> Handheld White board <input type="checkbox"/> Large Print <input type="checkbox"/> Lip Reading <input type="checkbox"/> Magnification Device <input type="checkbox"/> Mobility Assistance <input type="checkbox"/> None <input type="checkbox"/> Other (specify in comment field) <input type="checkbox"/> Phone relay services <input type="checkbox"/> Qualified Note taker <input type="checkbox"/> Qualified Reader <input type="checkbox"/> Service Animal <input type="checkbox"/> TTY Phone <input type="checkbox"/> Volume Control 	<p>Needs and Accommodation Comments:</p> <hr/> <hr/> <hr/> <hr/>
<p>Accessible Document Preference:</p> <hr/>	<p>Patient Type(s):</p> <hr/>	

State ID

Drivers License #: <hr/>	Driver's License State: <hr/>	
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EMERGENCY CONTACT INFORMATION

Basic Info

Name:		
Gender:	DOB:	SSN:
Living Status:	Address link? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:		
City:	State:	Zip:
County:	Country:	
Same Household? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone:	Work Phone:	Mobile Phone:
Primary: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile	Email:	
Occupation:		
Notify on Admission? <input type="checkbox"/> Yes <input type="checkbox"/> No		Authorized Letter Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship

Relationship: _____	Relationship Dates: _____ to _____	Role (start date, end date): _____
Medical Decision Maker: _____	Active MDM? <input type="checkbox"/> Yes <input type="checkbox"/> No	MDM Document (Upload):
Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Language/Accessibility

Preferred:	Spoken:	Written:
Interpreter Needed? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Hard of Hearing? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Low Vision? <input type="checkbox"/> Yes or <input type="checkbox"/> No
Hearing/visual needs: _____ _____ _____	Special needs: _____ _____ _____	



PCP AND PHARMACY INFO

Primary Care Provider

Add PCP:
Add Team Member:

Pharmacy (To be Completed by Pharmacy Only)

Preferred Pharmacy (Mark as Reviewed or Never Reviewed) <input type="checkbox"/> Reviewed <input type="checkbox"/> Never Reviewed
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COMMUNICATION PREFERENCES

General Communication Preference

	Mail	Phone	Email
General Communication Preference	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Account Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telehealth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Messages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

REFERRAL INFORMATION

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"/> Other/None: _____	