SUMMITSTONE HEALTH PARTNERS

SUMMITSTONE REGISTRATION – ADULT FORM (18+)

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

CLIENT ID NUMBER:	TODAY'S DATE:

PERSONAL INFORMATION

LAST NAME:	MIDDLE NAME:		FIRST NAME:
SEXUAL ORIENTATION:	☐ STRAIGHT/HETEROSEXUAL	☐ BISEXUAL	☐ OTHER
	☐ LESBIAN/GAY/HOMOSEXUAL	☐ PANSEXUAL	☐ NOT DISCLOSING OR N/A
GENDER IDENTITY:	☐ FEMALE	☐ MALE	☐ NON-BINARY
	☐ TRANSGENDER (MTF)	☐ TRANSGENDER (FTM)	☐ GENDERQUEER
ARE YOU PREGNANT	☐ YES	☐ NO	☐ 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? ☐ YES ☐ NO		
PHYSICAL ADDRESS:	CITY:	STATE:	ZIP:
COUNTY:			

PLEASE PROVIDE AT LEAST ONE METHOD OF CONTACT

PHONE NUMBER:	☐ HOME	☐ CELL PHONE	☐ WORK
ARE VOICE MESSAGES OKAY? ☐ YES ☐ NO	ARE TEXT MESSAGES OKAY? ☐ YES ☐ NO		
PHONE NUMBER:	☐ HOME		
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
EMAIL ADDRESS:					
PRIMARY LANGUAGE:					

ETHNICITY (USED FOR DEMOGRAPHIC DATA)

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

RACE (CHECK ALL THAT APPLY)

☐ American Indian/Alaska Native	☐ Asian	☐ Black/African American	☐ Native Hawaiian/Pacific Islander
☐ MENA: Middle Eastern/North African	☐ White/Caucasian	☐ South Asian	☐ Other

HIGHEST LEVEL OF EDUCATION COMPLETED

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

SUMMITSTONE HEALTH PARTNERS

EMPLOYMENT STATUS

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

MARITAL STATUS

☐ Married	☐ Divorced	☐ Never Married	☐ Widowed	☐ Separated

SMOKING STATUS

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

CURRENT LIVING ARRANGEMENT (CHECK ALL THAT APPLY)

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

VETERAN STATUS

☐ Not a Veteran	☐ Veteran Branch:
Dates of Military Service - from _____ to _____	

EMERGENCY CONTACT

Contact Name:	Relationship:	Phone Number:
Does the Emergency Contact live with the client? ☐ YES ☐ NO		

TREATMENT INFORMATION *(This information is only used to assure appropriate treatment.)*

PLEASE CHECK ALL THAT DESCRIBE YOUR NEEDS

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

REFERRAL INFORMATION

Were you referred to treatment? ☐ YES ☐ NO	IF YES, BY WHOM?
Are you in need of a court-ordered treatment or assessment? If yes, check all that apply. ☐ YES ☐ NO	
☐ 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: Number of arrests in last 30 days: Number of DUI arrests in last 30 days:
☐ Other/None:	