SUMMITSTONE HEALTH PARTNERS

REGISTRATION FORM SYMPTOM CHECKLIST – YOUTH (12-17)

Please mark any current symptoms or symptoms experienced within the last two weeks

ANXIETY				
☐ Agitation	☐ Fatigue	☐ Dissociative Episodes	☐ Phobia	☐ Irritability
☐ Restlessness	☐ Sleep Disturbances	☐ Poor Concentration	☐ Excessive Worry	☐ Tension
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				

DELUSIONS		
☐ Grandiose	☐ Religious	☐ Somatic
☐ Paranoia	☐ Persecution	☐ Self-Deprecation
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS		

PANIC			
☐ Heart Palpitations	☐ Chest Pain	☐ Dizziness	☐ Hot Flashes
☐ Shortness of Breath	☐ Nausea	☐ Chills	
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS			

MANIA		
☐ Grandiosity	☐ Pressured Speech	☐ Increased Activity
☐ Euphoria	☐ High-Risk Behaviors	☐ Impulsivity
☐ Decreased Sleep	☐ Racing Thoughts	☐ Irritability
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS		

DEPRESSION		
☐ Changes in Sleep	☐ Changes in Appetite	☐ Psychomotor Retardation
☐ Fatigue	☐ Hopelessness	☐ Changes in Weight
☐ Suicidal Ideation	☐ Agitation	☐ Diminished Self-Esteem
☐ Feeling sad or down most days	☐ Not enjoying the things you used to	☐ Excessive Guilt
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS		

BEHAVIOR/IMPULSE			
☐ Physical Aggression	☐ Pulling Hair Out	☐ Verbal Aggression	☐ Aggressive Impulses
☐ Excessive Spending	☐ Self-Injurious Behavior	☐ Attachment Issues	☐ Rageful Episodes
☐ Assaultive Behavior	☐ Legal Problems	☐ Hostility	☐ Sexually Assaultive
☐ Suicidal Gestures	☐ Damage to Property	☐ Stealing	☐ Fire Setting
☐ Enuresis	☐ Defiant	☐ Impulsivity	☐ Domestic Violence
☐ Maladaptive Gambling	☐ Unruly	☐ Drug/Alcohol Abuse	☐ Encopresis
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS			

ABUSE/TRAUMA		
☐ Avoid Stimuli associated with Trauma	☐ Hyperarousal	☐ Flashbacks
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS		

EATING DISORDER		
☐ Intense Fear of Gaining Weight	☐ Absence of Menstruation	☐ Weight Loss
☐ Distorted Body Image	☐ Binge Eating	☐ Weight Gain
☐ Laxative Abuse	☐ Diuretic Abuse	☐ Compulsive Overeating
☐ Induced Vomiting	☐ Fasting	
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS		

LEARNING / ATTENTION			
☐ Difficulty Writing	☐ Difficulty Reading	☐ Difficulty with Mathematics	☐ Difficulty with Verbal Expression
☐ Developmental Delays	☐ Developmental Disability	☐ Hyperactivity	☐ Poor Attention
☐ Truancy	☐ Dyslexia	☐ Difficulty recognizing letters	
☐ I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS			

SUMMITSTONE HEALTH PARTNERS

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

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:

FAMILY HISTORY: HAS CLIENT OR ANY BLOOD RELATIVE SUFFERED FROM ANY OF THE FOLLOWING?

Cancer					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Suicide / Suicide Attempts					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Heart Disease / Stroke					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Anxiety					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Diabetes					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Thyroid Trouble					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Paranoia / Psychosis					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Schizophrenia					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Other Hormonal Illness					

☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Bi-Polar Depression					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
History of Head Injuries					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Depression					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Neurological Disease					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Alcoholism					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Epilepsy / Seizures					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					
Drug Addiction					
☐ Client	☐ Mother	☐ Father	☐ Siblings	☐ Grandparent	☐ Aunt/Uncle
☐ NONE/OTHER					

Do you have an Advance Directive (living will/medical durable power of attorney)?	☐ Yes	☐ No
Will you or your Parent/Guardian 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	☐ Other
☐ NONE		

CURRENT MEDICATIONS

☐ Abilify	☐ Lamictal	☐ Zoloft	☐ Trazodone
☐ Lamotrigine	☐ Concerta	☐ Seroquel	☐ Lithium Carbonate
☐ Clonazepam	☐ Clozapine	☐ Other	
☐ NONE			

CURRENT NON-MEDICATION ALLERGIES (MARK ALL THAT APPLY)

☐ Seasonal Allergies	☐ Latex	☐ Shellfish	☐ Pollen	☐ Bee Stings
☐ Grasses	☐ Mold	☐ Nuts	☐ Gluten	☐ Cats
OTHER CURRENT NON-MEDICAL ALLERGIES:				
☐ NONE				

CURRENT ALLERGIES TO MEDICATION

☐ Penicillin	☐ Codeine	☐ Morphine	☐ Aspirin
☐ Lamictal	☐ Vicodin	☐Wellbutrin	☐ Ibuprofen

OTHER CURRENT ALLERGIES TO MEDICATION:
☐ NONE