



REGISTRATION FORM SYMPTOM CHECKLIST – YOUTH (12-17)

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

ANXIETY				
<input type="checkbox"/> Agitation	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Tension	<input type="checkbox"/> Phobia	<input type="checkbox"/> Irritability
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Excessive Worry	<input type="checkbox"/> Dissociative Episodes
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
DELUSIONS				
<input type="checkbox"/> Grandiose		<input type="checkbox"/> Religious		<input type="checkbox"/> Somatic
<input type="checkbox"/> Paranoia		<input type="checkbox"/> Persecution		<input type="checkbox"/> Self-Deprecation
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
PANIC				
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hot Flashes	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Nausea	<input type="checkbox"/> Chills		
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
MANIA				
<input type="checkbox"/> Grandiosity		<input type="checkbox"/> Pressured Speech		<input type="checkbox"/> Increased Activity
<input type="checkbox"/> Euphoria		<input type="checkbox"/> High-Risk Behaviors		<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Decreased Sleep		<input type="checkbox"/> Racing Thoughts		<input type="checkbox"/> Irritability
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
DEPRESSION				
<input type="checkbox"/> Changes in Sleep		<input type="checkbox"/> Changes in Appetite		<input type="checkbox"/> Psychomotor Retardation
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Hopelessness		<input type="checkbox"/> Changes in Weight
<input type="checkbox"/> Suicidal Ideation		<input type="checkbox"/> Agitation		<input type="checkbox"/> Diminished Self-Esteem
<input type="checkbox"/> Not enjoying the things you used to		<input type="checkbox"/> Feeling sad or down most days		<input type="checkbox"/> Excessive Guilt
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
BEHAVIOR/IMPULSE				
<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Pulling Hair Out	<input type="checkbox"/> Verbal Aggression	<input type="checkbox"/> Aggressive Impulses	
<input type="checkbox"/> Excessive Spending	<input type="checkbox"/> Self-Injurious Behavior	<input type="checkbox"/> Attachment Issues	<input type="checkbox"/> Rageful Episodes	
<input type="checkbox"/> Assaultive Behavior	<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Hostility	<input type="checkbox"/> Sexually Assaultive	
<input type="checkbox"/> Suicidal Gestures	<input type="checkbox"/> Damage to Property	<input type="checkbox"/> Stealing	<input type="checkbox"/> Fire Setting	
<input type="checkbox"/> Enuresis	<input type="checkbox"/> Defiant	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Domestic Violence	
<input type="checkbox"/> Maladaptive Gambling	<input type="checkbox"/> Unruly	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Encopresis	
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
ABUSE/TRAUMA				
<input type="checkbox"/> Avoid Stimuli associated with Trauma		<input type="checkbox"/> Hyperarousal		<input type="checkbox"/> Flashbacks
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
EATING DISORDER				
<input type="checkbox"/> Intense Fear of Gaining Weight	<input type="checkbox"/> Absence of Menstruation	<input type="checkbox"/> Distored Body Image	<input type="checkbox"/> Binge Eating	
<input type="checkbox"/> Compulsive Overeating	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fasting	
<input type="checkbox"/> Laxative Abuse	<input type="checkbox"/> Diuretic Abuse	<input type="checkbox"/> Excessive Exercise		
<input type="checkbox"/> I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS				
LEARNING / ATTENTION				
<input type="checkbox"/> Difficulty Writing	<input type="checkbox"/> Difficulty Reading	<input type="checkbox"/> Difficulty with Mathematics	<input type="checkbox"/> Difficulty with Verbal Expression	
<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Poor Attention	
<input type="checkbox"/> Truancy	<input type="checkbox"/> Dyslexia	<input type="checkbox"/> Difficulty with Recognizing Letters		



I AM NOT EXPERIENCING ANY OF THESE SYMPTOMS

ASSESSMENT

Have you used drugs or alcohol today?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you using substances and have dependent children?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you on an involuntary commitment for substance use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a history of IV Drug Use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

CRAFT ASSESSMENT

Have you ever felt you should cut down on your drinking or drug use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/> YES	<input type="checkbox"/> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> 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					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Suicide / Suicide Attempts					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Heart Disease / Stroke					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Anxiety					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Diabetes					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Thyroid Trouble					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Paranoia / Psychosis					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Schizophrenia					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					

Other Hormonal Illness					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Bi-Polar Depression					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
History of Head Injuries					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Depression					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Neurological Disease					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Alcoholism					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Epilepsy / Seizures					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					
Drug Addiction					
<input type="checkbox"/> Client	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Siblings	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle
<input type="checkbox"/> NONE/OTHER					

Do you have an Advance Directive (living will/medical durable power of attorney)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will you authorize (sign a release of information) communication with your primary care provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ARE YOU TAKING ANY OF THE FOLLOWING?

<input type="checkbox"/> Prescriptions	<input type="checkbox"/> Diet Aids	<input type="checkbox"/> Caffeine
<input type="checkbox"/> Over-the-Counter Medications	<input type="checkbox"/> Herbs or Supplements	<input type="checkbox"/> Other
<input type="checkbox"/> NONE		

CURRENT MEDICATIONS

<input type="checkbox"/> Abilify	<input type="checkbox"/> Lamictal	<input type="checkbox"/> Zoloft	<input type="checkbox"/> Trazodone
<input type="checkbox"/> Lamotrigine	<input type="checkbox"/> Concerta	<input type="checkbox"/> Seroquel	<input type="checkbox"/> Lithium Carbonate
<input type="checkbox"/> Clonazepam	<input type="checkbox"/> Clozapine	<input type="checkbox"/> Other	
<input type="checkbox"/> NONE			

CURRENT NON-MEDICATION ALLERGIES (MARK ALL THAT APPLY)

<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Latex	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Pollen	<input type="checkbox"/> Bee Stings
<input type="checkbox"/> Grasses	<input type="checkbox"/> Mold	<input type="checkbox"/> Nuts	<input type="checkbox"/> Gluten	<input type="checkbox"/> Cats
OTHER CURRENT NON-MEDICAL ALLERGIES:				
<input type="checkbox"/> NONE				

CURRENT ALLERGIES TO MEDICATION

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Morphine	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Lamictal	<input type="checkbox"/> Vicodin	<input type="checkbox"/> Wellbutrin	<input type="checkbox"/> Ibuprofen
OTHER CURRENT ALLERGIES TO MEDICATION:			
<input type="checkbox"/> NONE			