Lytle Behavioral Health

(866) 468-0638
200 Cedar Ridge Dr., Suite 208 Pittsburgh, PA 15205
2200 Garden Dr., Suite 200B Seven Fields, PA 16046
160 Canal St. Hollidaysburg, PA 16648

Form Instructions/Client Forms:

Please fill out this first packet of stapled forms to the best of your ability. Feel free to leave any questions blank if you are unsure of your answer. You can then talk to your counselor about your concern.

Thank you

Lytle Behavioral Health

(866) 468-0638
200 Cedar Ridge Dr., Suite 208 Pittsburgh, PA 15205
2200 Garden Dr., Suite 200B Seven Fields, PA 16046
160 Canal St. Hollidaysburg, PA 16648

Adolescent Demographic Information

Today's Date _____

Parent's (Insured's) Name:_____

Parent's (Insured's) Date of Birth:_____

Adolescent's Name:_____

Age: _____ Date of Birth: _____ Social Security Number:_____

Address:_____

_____

Home Phone:_____ Msg ok? Y N

Cell Phone: _____ Msg ok? Y N

Parent's Work/Cell Phone:_____ Msg ok? Y N

School:_____ Grade:_____

Job (if you have one): _____

Family Information Name / Ages / Occupation

Mother:_____

Father:_____

Stepmother:_____

Stepfather: _____

Siblings:_____

_____

If your parents are divorced, what is custody agreement? _____

Lytle Behavioral Health

(866) 468-0638
200 Cedar Ridge Dr., Suite 208 Pittsburgh, PA 15205
2200 Garden Dr., Suite 200B Seven Fields, PA 16046
160 Canal St. Hollidaysburg, PA 16648

Adolescent's Name & D.O.B.:_____

Previous or current counseling/therapy

Dates Name of Therapist

_____

_____

Do you use alcohol? YES/NO Amount: _____ Frequency: _____

Do you use tobacco products? YES/NO Type:_____ Frequency:_____

Do you use other drugs? YES/NO What types:_____
Amount:_____ Frequency: _____

Name of Pediatrician/Primary Care Physician:_____

Please list all medications you are currently taking:

Name of medication Purpose Prescribed by How long have you been taking?

_____

_____

Is there a history of depression, anxiety, etc. in your family? YES/NO

Family Member: _____ Condition: _____
Did they or are they currently receiving treatment? YES/NO

Referred by (if other than insurance company):_____

Please sign here if I have your permission to release information to your insurance company in order for them to process you claim and pay me directly.

_____ Date: _____
Client signature

_____ Date: _____
Parent/guardian signature

In case of an emergency, please give the name and phone number of a person I could call.

Name:_____ Relationship:_____

Phone:_____

Lytle Behavioral Health

(866) 468-0638
200 Cedar Ridge Dr., Suite 208 Pittsburgh, PA 15205
2200 Garden Dr., Suite 200B Seven Fields, PA 16046
160 Canal St. Hollidaysburg, PA 16648

Adolescent Checklist of Concerns

Name: _____

Date:_____Date of Birth:_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

____ Strong feelings of anger
____ Feeling down or blue
____ Trouble sleeping
____ Unable to control your temper
____ Disliking yourself
____ Problems with friends
____ Problems with family/stepfamily; if checked, with whom:_____
____ Poor appetite
____ Poor grades
____ Being bullied/picked on at school
____ Nightmares
____ Difficulty making decisions
____ Feeling anxious or tense
____ Problems with drugs or alcohol
____ Feeling that people are unfriendly or dislike you
____ Not feeling well physically
____ Crying more than usual
____ Boyfriend/girlfriend issues
____ Thoughts of ending your life
____ Thoughts of harming someone else
____ Issues with teachers
____ Problems with police/law
____ Weight issues
____ Traumatic event
____ Victim of Violence

Any other concerns or issues:
_____
_____

Please look back over the concerns you have checked off and choose those that you most want help with. What most concerns you?
_____

Lytle Behavioral Health

(866) 468-0638
200 Cedar Ridge Dr., Suite 208 Pittsburgh, PA 15205
2200 Garden Dr., Suite 200B Seven Fields, PA 16046
160 Canal St. Hollidaysburg, PA 16648

Acknowledgement

By my signature below, I acknowledge that I have received copies of the following documents:

1. Healthcare Information Portability and Accountability Act (HIPAA) privacy notification handout
2. Office Policies handout
3. Financial Policies handout

We strongly urge you to take enough time to read and understand the content of these items carefully. Many patients have questions about insurance coverage, co-payments, deductibles, and financial responsibility for office visit payments. Clarification of these issues now will go a long ways towards preventing any confusion later on in your treatment process. We will gladly answer any questions you may have about our policies and procedures. Please feel free to ask now or at any time in the future.

Counseling/psychotherapy is a partnership between the client and therapist. Your clinician will provide feedback on the situations/concerns presented and review expectation/goals for treatment. Your signature shows that the material listed on the Office Policies and Financial Policies have been reviewed and you understand to the best of your ability. If you have any questions/concerns, please review these with your clinician. Your feedback and satisfaction are important.

Upon your therapist's sudden disability or death, your files will be confidentially shredded by our office intake staff in a timely manner.

Signature of Adolescent

Printed Name of Adolescent

Signature of Parent/Guardian

Printed Name of Parent/Guardian