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

Today's Date _____

Name (First Middle Last): _____

Date of Birth:_____Social Security Number:_____

Address: _____

_____

Telephone Numbers: (Home) _____ (Cell) _____

(Work) _____

May we call you at home? YES/NO May we call you at work? YES/NO

May we leave a message on your cell phone? YES/NO At work? YES/NO

Email Address: _____ May we email appointment reminders? YES/NO
May we email you educational communications? YES/NO

Occupation: _____ Employer:_____

Level of education completed: _____

Marital Status (Please circle one):

Married Re-Married Partnered Single Separated Divorced Widowed

Family/Members of household and Ages:

_____

_____

_____

Has a medical doctor treated you in the last 6 months? YES/NO

For what medical condition? _____

Are you still being treated? YES/NO

Current medical condition concerns:_____

Chronic conditions: _____

Has you physician referred you? YES/NO

Allergies:_____

Primary Care Physician: _____ Phone: _____

Psychiatrist (if applicable): _____

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Name: _____Date of Birth:_____

Previous or current counseling/therapy:

Dates Name of Therapist

_____

_____

_____

Have you ever been hospitalized for a mental health condition? YES/NO

Where? _____ When? _____

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: _____

Please list all medications you currently take:

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

If you wish, you may write the current stressors affecting your mental health and the principle reason you are seeking help:

_____

_____

_____

Referred by (if other than insurance company):_____ Please sign here if I may thank them for referring you:

_____ Date: _____

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: _____

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

Name:_____ Phone:_____Relationship: _____

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Adult Checklist of Concerns (Page 1 of 2)

Name: _____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. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use-prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems-overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits

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Adult Checklist of Concerns (Page 2 of 2)

Name: _____Date of Birth:_____

- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems-too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, work-a-holism/overworking, can't keep a job

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?

_____

_____

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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
4. Electronic Communication 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.

_____

Printed Name

_____ _____

Client Signature

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