YOUTH INFORMATION FORM
LIFESTANCE HEALTH, INC.

Name: _____ **Date:** _____
Address: _____ **Date of Birth:** _____/_____/____
City: _____**State** _____**Zip** _____ **Gender:** ____
Phone: _____ **Text Ok?** ____ **Message Ok?** _____

Parent/Legal Guardian Contact Phone Numbers
Please complete relevant information and check boxes of parents or legal guardians.

OK to leave message?

☐ Mother's Name: _____ ☐
Home Phone: ( ) _____ ☐
Work Phone: ( ) _____ ☐
Cell Phone: ( ) _____ ☐

☐ Father's Name: _____
Home Phone: ( ) _____ ☐
Work Phone: ( ) _____ ☐
Cell Phone: ( ) _____ ☐

☐ Step-Mother's Name: _____
Home Phone: ( ) _____ ☐
Work Phone: ( ) _____ ☐
Cell Phone: ( ) _____ ☐

☐ Step-Father's Name: _____
Home Phone: ( ) _____ ☐
Work Phone: ( ) _____ ☐
Cell Phone: ( ) _____ ☐

☐ Legal Guardian's Name: _____
Home Phone: ( ) _____ ☐
Work Phone: ( ) _____ ☐
Cell Phone: ( ) _____ ☐

Insurance Information: _____

Emergency Contact Information (other than the people noted above)

Name: _____ Home Phone: ( ) _____
Work Phone: ( ) _____ Cell Phone: ( ) _____
Relationship to youth: _____
Emergency Dental resource: _____
Emergency Medical resource: _____

Primary Care Provider Information

Current Provider/Group Name: _____
Provider Address: _____
Provider Phone: ( ) _____ Fax: ( ) _____

School Information

Current School: _____ Primary Teacher Name: _____
Main contact at school: _____ Phone: ( ) _____

Referent Information

Referent information: Name: _____ Agency: _____
Phone:_____ Fax: _____

Presenting Problem:

_____
_____