Kyra F. Riddell, MA
Licensed Marriage and Family Therapist, Lic. 98921

TEEN INTAKE INFORMATION

Date _____/_____/_____

PARENT/GUARDIAN INFORMATION:

Name of Parent/Guardian Filing Out Form (if applies): _____

Relationship to Teen: _____

Primary Email: _____

Primary Phone #: _____, Can I leave you a message? Y / N

Work Phone #: _____, Can I leave you a message? Y / N

Address: _____

Who Referred You? _____

CLIENT INFORMATION:

Client name: _____ DOB: _____/_____/_____

Address: _____

Second Address (if applies): _____

Physician: _____ Physician Phone: _____

Date Last Seen: _____/_____/_____ Reason for Visit: _____

When was last time teen had a complete physical exam? _____

Previous Psychotherapy? Y / N If yes, When, How Long, and With Whom? _____

_____

Any Major Illnesses, Accidents or Surgeries? _____

_____

Current Medications? _____

Kyra F. Riddell, MA, LMFT Lic.98921
790 East Santa Clara St, Suite 105A, Ventura, CA 93001
(805) 669-8115 ≈ FAX (805) 309-2469
kyrariddell.lmft@gmail.com ≈ kyrariddell.com

FAMILY MEMBERS: ***Name, Birth date, Relationship, Living at home?***

_____ ____/____/____ _____ ***Y/ N***

_____ ____/____/____ _____ ***Y/ N***

_____ ____/____/____ _____ ***Y / N***

_____ ____/____/____ _____ ***Y / N***

_____ ____/____/____ _____ ***Y / N***

EMERGENCY CONTACT:

Name: _____ Relationship to Client: _____

Primary Telephone: _____

Address: _____

PRESENT DIFFICULTIES:

Please describe teen's present difficulties:

Problem	**When was problem first noticed**	**By Whom?**

In terms of discipline, how have you tried to address issues (e.g., loss of privileges, grounded, send to room, talk it through)? How did your teen respond?

_____

_____

_____

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Which of these problems are you most concerned about?

_____

_____

_____

Are there any current environmental stressors in the child's life at home, socially, or at school? Such as an illness, fighting, financial stress, divorce, alcoholism, or bullying

_____

_____

_____

Any past traumas or major stressors such as car accidents, divorce, difficult move, loss of a loved one, or other significant events worth noting? _____

_____

_____

What prompted you to contact me at this time?

_____

_____

_____

Please list any other information you think might be of assistance to me in understanding and helping your child: _____

_____

_____

_____

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Please circle any of the following that apply:

***Headaches**

***Dizziness**

***Fainting Spells**

***Stomach trouble**

***Bowel disturbances**

***Bed –wetting**

***Under eating**

***Over eating**

***Often sick**

***Allergies**

***Tired all the time**

***Sleeps too much**

***Can't sleep at night**

***Nightmares**

***Difficulty sleeping alone**

***Unable to relax**

***Nervous**

***Fearful**

***Too active**

***Startles easily**

***School Problems**

***Concentration difficulties**

***Overly ambitious**

***Memory problems**

***Speech difficulties**

***Learning difficulties**

***Can't make friends**

***Shy**

***Lonely**

***Gets bullied around**

***Bullies others**

***Inferiority feelings**

***Suicidal Ideas**

***Cutting**

***Alcohol abuse**

***Drug abuse**

***Inappropriate touch with others**

***Provocative dress**

***Sexually active**

***Doesn't get along with mother**

***Doesn't get along with father**

***Unable to get along with siblings**

***Irritable**

***Angry**

***Aggressive**

***Hitting**

***Yelling**

***Defiant**

***Passive aggressive**

***Passive**

***Withdrawn**

***Depressed**

***Loss of interest in hobbies**

***Unable to have a good time**

***Other:**

_____

_____

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