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Intake Information

Date: _____

NAME: _____

ADDRESS: _____ Apt: _____

CITY: _____ Zip: _____

BIRTHDATE: _____ AGE: _____

PLEASE INDICATE HOW I CAN CONTACT YOU. YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS. IF YOU DO NOT WANT YOUR BILLS OR CONFIDENTIAL INFORMATION SENT TO YOUR HOME ADDRESS, I WILL SEND THEM TO A DIFFERENT LOCATION IF YOU WISH.

ALTERNATIVE ADDRESS FOR CONFIDENTIAL COMMUNICATIONS TO BE SENT _____

PLEASE INDICATE WHICH PHONE IT IS OKAY TO LEAVE A MESSAGE ON

Phone: **Home** _____ msg? _____ **Email:** _____
Cell _____ msg? _____ **Text message OK?: (circle one) YES NO**

Who do we contact in case of an emergency?

Name/Phone: _____

Who Referred you? _____

Do I have your permission to contact the listed referring person to thank them?: _____ YES _____ NO

Family Members and Others Now in Household

Name	Relationship	Age	Marital Status
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Religion: _____ Education: _____

Employer: _____ Occupation: _____

How many hours/week are you employed? _____

How long have you worked at your current job? _____

Have you ever been fired or let go from a job? _____

If so, please explain circumstances _____

Has there been a major change in your income recently or has income stopped? ___yes ___no

Legal history:

Have you ever been arrested? Yes No

Have you ever been convicted of a crime? Yes No

Are you presently on parole or probation? Yes No

If yes, please explain _____

Are you currently, or have been involved in a lawsuit? ___Yes ___No

If yes, please explain: _____

Marital/Partner History--Please give year of marriage

From _____ To _____

From _____ To _____

How many children do you have? _____

Do they live with you? Yes No

Are you currently in litigation over custody or divorce? ___yes ___no If yes, please explain _____

Counseling History

Have you been in counseling in the past? ___yes ___no Reason for counseling _____

Have those issues been resolved? ___yes ___no Would you like to continue working on them? ___yes ___no

Therapist name _____ dates of counseling _____

Therapist name _____ dates of counseling _____

Therapist name _____ dates of counseling _____

Have you ever considered suicide? If so please explain _____

Are you currently having suicidal thoughts? _____

Have you ever experienced physical, sexual or emotional abuse? No Yes

If so please explain: _____

Have you ever been hospitalized for Psychiatric Reasons? ___yes ___no

When and Where _____

Do you have a psychiatrist that you are currently seeing? ___yes ___no If so, please indicate name and address of psychiatrist _____

Below is a list of concerns commonly reported by people seeking counseling. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you. Please use the following scale:

Not at all 1 A little bit 2 Quite a bit 3 Extremely 4

- 1. Dealing with stress or pressure 1 2 3 4
- 2. Feeling sad, depressed or down 1 2 3 4
- 4. Difficulties related to sexual orientation/identity 1 2 3 4
- 5. Family relationships 1 2 3 4
- 6. Abuse in relationship with romantic partner/spouse 1 2 3 4
- 7. Feeling anxious, worried, or panicky 1 2 3 4
- 8. Feeling unmotivated, difficulty concentrating 1 2 3 4
- 9. Feeling irritable, tense, angry, or hostile 1 2 3 4

10. Money or finances	1	2	3	4
11. Feeling isolated and uncomfortable with others	1	2	3	4
12. Values, beliefs, or spirituality concerns	1	2	3	4
13. Sexual abuse in childhood	1	2	3	4
14. Physical or verbal abuse in childhood	1	2	3	4
15. Someone else's habits or behaviors	1	2	3	4
16. My own unwanted habits or behaviors	1	2	3	4
17. Rape, sexual assault, or sexual harassment	1	2	3	4
18. Eating concerns (i.e., bingeing, restricting, vomiting, laxative use)	1	2	3	4
19. Weight or body image concerns	1	2	3	4
20. Problems with romantic partner/spouse	1	2	3	4
21. Sexual concerns (i.e., pregnancy, sexual functioning, STD's)	1	2	3	4
22. Physical health problems	1	2	3	4
23. Urge to harm others	1	2	3	4
24. Concerns about my own drug or alcohol use	1	2	3	4
25. Thoughts of harming myself	1	2	3	4
26. Other (please explain below):	1	2	3	4

Substance Abuse/Compulsive Behavior History

Have you ever been hospitalized for Substance abuse problems, or any type of compulsive behavior/addiction? ___yes
 ___no When/Where, Please explain _____

Please show your history of substance abuse/compulsive behavior, using the following scale
 1-Never use 2-Monthly 3-Weekly 4-Daily

History:	Current	Past
Alcohol	_____	_____
Tobacco	_____	_____
Caffeine	_____	_____
Cocaine	_____	_____
Marijuana	_____	_____
Stimulants	_____	_____
Diet Pills	_____	_____
Narcotics/Pain Killers	_____	_____
Sleeping Pills	_____	_____
Gambling	_____	_____
Shopping	_____	_____
Pornography	_____	_____

Are you, or have you ever been, concerned that you might have an addiction?_____ Please explain_____

Have you ever lost time from work due to substance use or addictive behaviors?_____

Have you ever been arrested for DUI or other alcohol/drug-related offenses?
 ___Yes ___No, if so how many times?_____

Have you ever been arrested for shoplifting?_____

Have you ever chosen to quit/cut down? _____ Yes _____ No

Have you ever experienced withdrawal symptoms _____ Yes _____ No

Have other (family, friend, spouse, MD, employee) expressed concern or anger about your alcohol/drug use?
 _____ Yes _____ No

Has anyone in your family had a history of heavy alcohol/drug use? No Yes
 If yes who _____

Medical History/Medication

<u>Current Medication</u>	<u>Dose Frequency</u>	<u>Prescribing Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician: _____

Address: _____

City: _____ Zip _____

Office Phone number: _____

Do we have your permission to send information regarding your care to your Primary MD?

Yes _____ No _____ Initial _____

Family History

Relationship:

Emotional Problems	Yes	No
Substance Abuse	Yes	No

Personal History

Emotional Problems	Yes	No	Substance Abuse	Yes	No
Cardiovascular Disease	Yes	No	Hypertension	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Abnormalities	Yes	No	Tuberculosis	Yes	No
Head Injuries	Yes	No	Cancer	Yes	No
Respiratory Disease	Yes	No	Other	_____	
Neurological Disorders	Yes	No			

Do you smoke? _____ How much per day _____ For how many years _____

Caffeine? _____ How much per day _____ For how many years _____

Please provide a summary of your counseling needs and goals. What brought you here, and what problems would you like to address in counseling: _____

Signature of Patient or Guardian _____ Date _____