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## Minor Intake

Date: \_\_\_\_\_

**Name of Child/Minor:** \_\_\_\_\_ **DOB** \_\_\_\_\_

Address and phone number that child resides \_\_\_\_\_  
\_\_\_\_\_ Zip code \_\_\_\_\_

**Father's name:** \_\_\_\_\_ **Age** \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: H \_\_\_\_\_ Msg? Yes \_\_\_\_ No \_\_\_\_ Cell \_\_\_\_\_ Msg? Yes \_\_\_\_ No \_\_\_\_

**Mother's name:** \_\_\_\_\_ **Age** \_\_\_\_\_

Address: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: H \_\_\_\_\_ Msg? Yes \_\_\_\_ No \_\_\_\_ Cell \_\_\_\_\_ Msg? Yes \_\_\_\_ No \_\_\_\_

**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  
ZIP \_\_\_\_\_

Who do I contact in case of an emergency?

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Family Members and Others Now in Household

| Name | Relationship | Age | Marital Status |
|------|--------------|-----|----------------|
|------|--------------|-----|----------------|

|       |       |       |       |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Who Referred you? \_\_\_\_\_

May I contact them **ONLY** for purposes to thank them for the referral? NO YES

Please provide a brief summary to describe the reason you are here today. How long has/have the problem(s) existed and what have you done to try to correct the problem. Please include pertinent family history, including how other people in the family have been affected.

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Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip \_\_\_\_\_  
Office Phone number: \_\_\_\_\_

Is your child on medication? Yes \_\_\_\_\_ No \_\_\_\_\_

| <b>Current Medication</b> | <b>Dose</b> | <b>Frequency</b> | <b>Present</b> | <b>In past</b> |
|---------------------------|-------------|------------------|----------------|----------------|
|---------------------------|-------------|------------------|----------------|----------------|

|       |       |       |       |       |
|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Prescribing Physician: \_\_\_\_\_

**Education/Grade:** \_\_\_\_\_

Current school minor attends \_\_\_\_\_

Problems in school: NO YES: \_\_\_\_\_

Has your minor ever had school problems due to drinking/drug use? \_\_\_\_\_

### **Counseling History**

Does your child have a Psychiatrist? \_\_\_\_\_

Prior psychological consultation, counseling, or ADHD testing? No \_\_\_\_ Yes \_\_\_\_

When and with Whom? \_\_\_\_\_

What issues did your child have at that time?

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Has your child ever been hospitalized for Psychiatric Reasons? No Yes

When and Where \_\_\_\_\_

\*\*Has your child ever considered suicide? If so please explain \_\_\_\_\_

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### **Developmental/Family history**

Is your child adopted? \_\_\_\_yes \_\_\_\_no If yes, at what age? \_\_\_\_\_

Open adoption? \_\_\_\_yes \_\_\_\_no

Contact with the birth parent(s)? \_\_\_\_yes \_\_\_\_no. Please give relevant adoption details \_\_\_\_\_

Marital/Parent History--Please give year of marriage

From \_\_\_\_\_ To \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

How many children in the family? \_\_\_\_\_

During pregnancy, did mother use: \_\_ Cigarettes\_\_ Alcohol\_\_ Drugs \_\_ Experience Extreme Stress?  
Specify frequency, amounts, and duration: \_\_\_\_\_

List any birth complications (Ex: Premature, jaundice, C-section, etc.) \_\_\_\_\_

Medical conditions or history (surgeries, asthma, chronic illness) \_\_\_\_\_

In the first two years, did your child experience: \_\_Separation from mother \_\_Out of home care  
\_\_Disruption in bonding \_\_Depression of mother \_\_Abuse \_\_Neglect \_\_Chronic pain  
\_\_Chronic Illness, \_\_Parental Stress

If yes, please specify:

Reached developmental milestones: \_\_On time \_\_Early \_\_Late

How many times has your child moved homes? \_\_\_\_\_

Have children witnessed domestic violence? \_\_Y, \_\_N, Specify: \_\_\_\_\_

How is your child disciplined? Please list each method and frequency of use: \_\_\_\_\_

Has your child been verbally abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Has your child been physically abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Has your child been sexually abused? \_\_Y, \_\_N, \_\_Suspected. Specify: \_\_\_\_\_

Has your child experienced a traumatic event? If yes, please describe the nature of the trauma and the outcome. Were there initial or lasting emotional effects? If so, please explain in detail.  
\_\_\_\_\_  
\_\_\_\_\_

Other stressors or traumas (i.e. car accidents, bullying, separation from parents, losses)  
\_\_\_\_\_  
\_\_\_\_\_

**Circle the symptoms your child displays and list the number of times per week symptom is displayed:**

Anger      Anxiety/worries      Bed wetting      Acts out sexually  
 Conduct problems      Controlling      Day defecation      Unusual sexual knowledge  
 Day wetting      Defiance      Depression      Homicidal thoughts or actions      Insomnia  
 Dissociates      Hyperactivity      Masturbates excessively  
 Hyper vigilance      Hallucinations/Delusional thinking      Isolation      Lack of empathy  
 Lack of motivation      Lethargy      Low impulse control      Plays out violent themes  
 Low self-esteem      Lying      Nightmares      Plays out sexual themes  
 Obsessive thoughts      Rituals      Over/Under eating      Phobias      Peer problems Running Away  
 Shy      Sleeplessness      Stealing      Tantrums      Physical Symptoms, i.e. stomachaches

Please show your minor's history of substance abuse (if applicable) by using the following scale.  
 1-Daily      2-Weekly      3-Monthly      4-Never use

Alcohol/Drug History: (Frequency)

Current

Past

Alcohol \_\_\_\_\_  
 Tobacco \_\_\_\_\_  
 Caffeine \_\_\_\_\_  
 Cocaine \_\_\_\_\_  
 Marijuana \_\_\_\_\_  
 Stimulants \_\_\_\_\_  
 Diet Pills \_\_\_\_\_  
 Narcotics/Pain Killers \_\_\_\_\_  
 Sleeping Pills \_\_\_\_\_  
 Other: \_\_\_\_\_

Has your child ever been arrested for DUI or other alcohol/drug-related offenses?  
 \_\_\_\_ No \_\_\_\_ Yes, if so how many times? \_\_\_\_\_

Have they tried to quit/cut down? \_\_\_\_\_ No \_\_\_\_\_ Yes

Have they experienced withdrawal symptoms \_\_\_\_\_ No \_\_\_\_\_ Yes

Have other (family, friend, spouse, MD, employee) expressed concern or anger about your child's alcohol/drug use? \_\_\_\_\_ Yes \_\_\_\_\_ No

Has anyone in your family, including yourself, had a history of heavy alcohol/drug use? No Yes  
 If yes who \_\_\_\_\_

### **Legal:**

Has your child ever been arrested?      Yes      No  
 Has your child ever been convicted of a crime?      Yes      No  
 Is your child presently on probation?      Yes      No  
 If yes, please explain \_\_\_\_\_

## **Social Media/Texting**

Estimate how many hours your child spends online/texting:

Facebook \_\_\_\_\_  
You Tube \_\_\_\_\_  
Gaming \_\_\_\_\_  
Browsing \_\_\_\_\_  
Texting \_\_\_\_\_  
Other \_\_\_\_\_

Is this, or has this been a problem for you or your child? If so, please explain \_\_\_\_\_

## **Family History**

Relationship:

|                        |     |    |
|------------------------|-----|----|
| Emotional Problems     | Yes | No |
| Substance Abuse        | Yes | No |
| Cardiovascular Disease | Yes | No |
| Hypertension           | Yes | No |
| Kidney Disease         | Yes | No |
| Respiratory Disease    | Yes | No |
| Cancer                 | Yes | No |
| Diabetes               | 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 |                 |       |    |

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_