Moving inside out, LLC
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CLIENT INTAKE
SELF REPORT

1. IDENTIFYING INFORMATION:

Client's Name: _____ Today's Date:_____

Partner's Name(s) (if being seen together): _____

Address: _____ Apt#_____ City _____ State _____ Zip_____

Phone: (H) _____ (Cell) _____ (W)_____ Partner's _____
Message OK? Yes/No Yes/No Yes/No Yes/No

Client's Date of Birth:_____ Age:_____ Gender Identity:_____

Relationship Type/Status: _____ Sexuality Identity:_____

Ethnic Identity: _____ Other Social/Cultural Identities:_____

_____

Education: _____ Profession: _____

Occupation: _____ Years at current job: _____

Employer: _____ Student? Yes/No If yes, where/for what: _____

Biological Children/Age: _____

Adopted/Foster/Step or Other Children/Age: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

2. INSURANCE INFORMATION: <INPUT TYPE=\ CHECKBOX > §MACROBUTTON HTMLDirectUninsured/Self Pay (skip to section 3 if you check this box)

A. Name of Primary Insurance Carrier_____

Insurance Address: _____ City _____ State _____ Zip_____

Phone No. for Mental Health Benefits: _____

Insurance Identification Number: _____ Group Identification Number: _____

Deductible Amount: $_____ Met? Yes/No Co-pay per Session: $_____

Preauthorization required? Yes/No Obtained? Yes/No

Policyholder's Name (if different from Client): _____ DOB _____

Relationship of Client to Policyholder: _____ Policyholder's Employer:_____

B. Do you have secondary insurance coverage? Yes/No If yes, please provide the above information for secondary insurance company using the back of this form.

CLIENT OR AUTHORIZED PERSON'S SIGNATURE:

I authorize Erika Ruber, LCSW to communicate with my insurance company and to provide any medical or other information necessary for the purposes of processing a claim including obtaining authorization for services, benefit information, provision of services, coordination of care, and payment for services. I authorize payment of medical benefits directly to Erika Ruber, LCSW.

Signature _____ Date: _____

Printed Name _____

Client Name _____

3. WHAT BRINGS YOU TO THERAPY

Please describe what brings you here today: _____

_____

_____

_____

Please circle the number to rate the following according to the degree to which they are a challenge in your current life (1=little or no concern 6= extreme problem). Also, in the blank, indicate how long each problem has affected you. (*If you have questions about any of these items, please ask)*:			
Depression	1 2 3 4 5 6	Muscle Tension	1 2 3 4 5 6
Extreme Sadness	1 2 3 4 5 6	Headaches	1 2 3 4 5 6
Tiredness	1 2 3 4 5 6	Stomach problems	1 2 3 4 5 6
Feeling hopeless	1 2 3 4 5 6	Gambling	1 2 3 4 5 6
Tearfulness/excessive crying	1 2 3 4 5 6	Memory problems	1 2 3 4 5 6
Feelings of extreme energy	1 2 3 4 5 6	Making decisions	1 2 3 4 5 6
Irritability	1 2 3 4 5 6	Confusion	1 2 3 4 5 6
Anger/Rage	1 2 3 4 5 6	Changes in appetite	1 2 3 4 5 6
Difficulty concentrating/focusing	1 2 3 4 5 6	Weight gain/loss	1 2 3 4 5 6
Isolating	1 2 3 4 5 6	Dangerous Behavior	1 2 3 4 5 6
Shyness	1 2 3 4 5 6	Attention Deficit med:	1 2 3 4 5 6
Loneliness	1 2 3 4 5 6	Physical Pain	1 2 3 4 5 6
Feeling fearful/ Excessive worry	1 2 3 4 5 6	Inferiority Feelings	1 2 3 4 5 6
Boredom	1 2 3 4 5 6	Sexual Problems	1 2 3 4 5 6
Insomnia	1 2 3 4 5 6	Physical disability	1 2 3 4 5 6
Nightmares	1 2 3 4 5 6	Alcohol Use # drinks/wk:	1 2 3 4 5 6
Lack of energy	1 2 3 4 5 6	Caffeine # drinks/wk:	1 2 3 4 5 6
Nervousness	1 2 3 4 5 6	Tobacco # packs/wk:	1 2 3 4 5 6
Unhappiness	1 2 3 4 5 6	Other Drug Use type:	1 2 3 4 5 6
Manic Behavior	1 2 3 4 5 6	Sexual abuse/assault	1 2 3 4 5 6
Panic attacks	1 2 3 4 5 6	Acculturation	1 2 3 4 5 6
Sexualized thoughts	1 2 3 4 5 6	Separation/Divorce	1 2 3 4 5 6
Compulsive behavior	1 2 3 4 5 6	Relationship Issue	1 2 3 4 5 6
Obsessive Thoughts	1 2 3 4 5 6	Educational Issue	1 2 3 4 5 6
Binging/Purging	1 2 3 4 5 6	Parenting Issue	1 2 3 4 5 6
Feeling Guilty	1 2 3 4 5 6	Financial Issue	1 2 3 4 5 6
Feeling stressed	1 2 3 4 5 6	Problems at work	1 2 3 4 5 6
Ambition/Perfectionism	1 2 3 4 5 6	Legal Matter	1 2 3 4 5 6
Acting violently or aggressively	1 2 3 4 5 6	Health Care Issue	1 2 3 4 5 6
Thoughts about hurting or killing yourself	1 2 3 4 5 6	Targeted by racism, classism, heterosexism, ableism, and/or other oppression(s)	1 2 3 4 5 6

Client Name _____

What you have tried or are you trying now to resolve any of the above challenges: _____

_____

_____

_____

_____

_____

_____

4 PAST HISTORY

Have you ever received mental health, counseling, therapy, psychiatric or psychological help of any kind? Yes/No

Therapist's Name	Dates Seen	How it was/was not helpful

Have you ever been hospitalized? Yes/No If yes, what happened? _____

_____

_____

_____

Have you ever received treatment of any kind related to alcohol or other drugs, including prescription? Yes/No If yes, where and when:_____

_____

4. FAMILY HISTORY

Where were you primarily raised? _____ Rural/Urban/Suburban/Multiple moves/Homelessness

Please circle all that apply to your life:

Foster Care /Adopted	Domestic Violence	Drug abuse in family	Relative committed suicide
Raised by Grandparents/Relatives	Mother/father was Teen Parent	Abortion	Immigrant to US
Parents separated/divorced	Estranged from Parent/Sibling	Child Deceased	Lived Outside US
Step Parent	Parent Experienced Depression	Sibling Deceased	Military Service
Blended Family	Alcoholism in Family	Partner Deceased	Victim of Hate Crime
Self/Parent been in jail	Witnessed Community Violence	Chronic Illness	

Has anyone in your biological family been diagnosed with a mental illness? Yes/No If yes, please describe: _____

_____

_____

_____

_____

_____

5. YOUR LIFESTYLE AND SOCIAL CONTEXT

Other people living in the home:

Name					
Age/DOB					
Relationship					
Pets :					

What do you do for relaxation and enjoyment? _____

_____

Who are the most important people currently in your life? _____

_____

What kinds of social/political issues are most important to you? _____

_____

Do you have a spiritual belief system? If so, please explain: _____

_____

What do you value most in life? _____

_____

What kinds of physical activity do you enjoy? _____

How many times a week do you exercise? _____

How many meals do you eat per day? _____ How many times per week do you sit down with others to eat? _____

What are typical snack foods that you eat? _____

How many times per week do you eat foods from the following categories? Water _____ Soda/Pop/Cola _____ Home cooked _____

Frozen foods _____ Canned foods _____ Pre-prepared meals _____ Fresh foods _____ Fast Food _____ Restaurant _____

How many times per month do you receive any of the following kinds of care: Acupuncture _____ Massage _____

Physical Therapy _____ Chiropractic _____ Homeopathic/Naturopathic _____ Other alternative care _____

Name of your primary medical provider: _____ Phone No. _____

What medications are you currently taking (include vitamins/herbs)? _____

_____

What kinds of physical/medical conditions are currently problems for you? _____

_____

What kinds of recreational drugs and how often do you use (alcohol, cigarettes, etc)? _____

_____

Do you have allergies? Yes/No If yes, to what? _____

How many hours each week is the television on in your home? _____

What are your likes or dislikes about television? _____

_____

6. Body Mind Health and Wellness

I feel aware of the sensations in my body at all times.

Very aware somewhat aware barely aware not at all aware

I listen to the cues my body tells me and respond accordingly.

All the time sometimes barely never

Do you know what kind of movements gives your body pleasure? Do you move that way often?

In which realm do you feel that you reside most of the time?

Physical Mental Emotional Spirit

In which realm do you feel most balanced?

Physical Mental Emotional Spirit

In which realm do you feel most out of balance?

Physical Mental Emotional Spirit

Which realm would you like to get to know better?

Physical Mental Emotional Spirit

In your own words, please describe what you hope to gain from attending therapy.

_____

_____

_____

_____

_____

Client Name _____

Client Signature_____

Date_____