Moving inside out, LLC
Erika Ruber, LCSW
3500 NE MLK Jr. Blvd, Suite 200 Portland, OR 97212
p/503.680.7292 f/503.235.5455

TEEN CLIENT INTAKE

1. IDENTIFYING INFORMATION:

Client's Name: ______________________________ Today's Date: ____________

Client's Date of Birth: __________ Age: ______ Gender Identity: ____________________

Parent(s) Name(s): ______________________________

Parent__________'s Phone: (H) ______________ (Cell) ______________ (W)______________

Message OK? Yes/No Yes/No Yes/No

Address: ______________________ Apt # ______ City ____________ State ____ Zip ______

Employer ______________________ Position ______________________

Work schedule ______________________________

Parent__________'s Phone: (H) ______________ (Cell) ______________ (W)______________

Message OK? Yes/No Yes/No Yes/No

Address: ______________________ Apt # ______ City ____________ State ____ Zip ______

Employer ______________________ Position ______________________

Work schedule ______________________________

Custody Arrangement (if applicable): ______________________________

Emergency Contact: ____________________ Relationship: __________ Phone: __________

Who referred you to Moving inside out, LLC, Erika Ruber, LCSW? ______________________

2. INSURANCE INFORMATION:

Uninsured/Self Pay

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 Moving inside out, LLC, 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 Moving Inside Out, LLC/ Erika Ruber, LCSW.

Signature ______________________________ Date: ______________

Printed Name ______________________

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TEEN CLIENT INTAKE
SELF REPORT

This form may seem long, but the information on it will help me to better help you. What you write on this form is confidential unless it has to do with someone hurting herself or himself or someone else.

Adolescent Information

Name: ______________________________ Date of First Visit: ______________

Address: ______________________ Apt #_____ City_____________ State_____ Zip_________

Gender: _______________Age: _____Date of Birth: ______________

Ethnic Identity: ____________________ Other Social/Cultural Identities:____________________

____

Home Phone: ____________ OK to Call? Yes/No OK to Leave Message? Yes/No

Cell Phone: ____________ OK to Call? Yes/No OK to Leave Message? Yes/No

Parents or Legal Guardians: ______________________________

With whom do you live? ______________________________

Brought in for counseling by: ____________________ Relationship to you:______________

What school do you go to? ____________________Grade: ______________

Are you here because you want counseling or because someone else wants you to get counseling? I do: ____Someone else does: ____

Family Information

Your biological parents' names and ages: ______________________________

Other people besides you living in your home:

Name					
Age/DOB					
Relationship					
Pets:					

List names and ages of biological or stepbrothers or stepsisters who live somewhere else: ____________________

____

Have your parents been separated or divorced? ____ Yes ____No If yes, since when? ____________________

Were you adopted? Yes _____ No ______ If yes, at what age: _____

Have you ever lived in foster care or a similar living arrangement? Yes _____ No _____ If yes, at what age(s): ____________

Has there been a death of a family member? Yes _____ No _____

If yes, what relationship was this person to you? ____________________

History

Have there been any critical events in your life? Yes _____ No _____ If yes, please describe: ____________________

____

Have you ever been physically abused? Yes _____ No _____ Have you ever been sexually abused? Yes _____ No _____

Have you ever witnessed violence between adults? Yes _____ No _____

Have any of the other children living in your home been abused? Yes _____ No _____

Client Name ________________________

What do you do for fun and to relax? ________________________

How do you handle it when you feel angry? ________________________

How well are you doing with your home life? ________________________

How would you describe your interactions with your brothers and/or sisters? ________________________

How would you describe your interactions with your parent(s)? ________________________

With whom do you have the most conflict? Over what topics? ________________________

How would you describe your interactions with other people your own age? ________________________

How would you describe your interactions with adults? ________________________

What kinds of major stress have you experienced? ________________________

Have you ever drank alcohol or used other drugs? Yes _____ No _____ If yes, please list: ________________________

Are you sexually active (even kissing)? Yes _____ No _____ With: ____ boys ____ girls ____ both

Have you done any behavior that has legal implications? Yes _____ No ______ (shoplifting ,tagging, etc.)

What were the consequences? ________________________

How many hours a day do you spend on the Internet? __________ How many hours a day do you spend watching TV? ____________

How well do you do in school? ________________________

What would you like to be doing in 5 years? ________________________

Client Name ________________________

Counseling and Medical Information

Have you been in counseling before? Yes _____ No _____

If yes, where and with whom? ____________________

How helpful was it? ____________________

Have you ever had any major illnesses or injuries? Yes _____ No _____ If yes, please describe: ____________________

____

Have you ever been hospitalized? Yes _____ No _____ If yes, please describe: ____________________

____

Are you currently under any medical care for any illness? Yes _____ No _____

If yes, please describe: ____________________

Are you taking any medications? Yes _____ No _____ If yes, please list: ____________________

____

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

Has anyone in your family been diagnosed with a mental illness? Yes _____ No _____

Has anyone in your family had a problem with alcohol or other drugs? Yes _____ No _____

Has anyone in your family has a quick temper or problem with anger? Yes _____ No _____ If yes, who ____________________

How much attention do you pay to your physical health? Please explain: ____________________

____

____

Please rate the following according to the degree to which they are a challenge in your current life (*If you have questions about any of these items, please ask)*:

1=not a problem at all 2= rarely a problem 3=somewhat of a problem 4= a problem 5= a pretty big problem 6= extreme problem

Feeling down/depressed	1 2 3 4 5 6	Muscle Tension	1 2 3 4 5 6
Feeling sad	1 2 3 4 5 6	Headaches/Stomach aches	1 2 3 4 5 6
Feeling tired	1 2 3 4 5 6	Disorganization	1 2 3 4 5 6
Feeling hopeless	1 2 3 4 5 6	Difficulty making decisions	1 2 3 4 5 6
Crying/Tearfulness	1 2 3 4 5 6	Peer pressure	1 2 3 4 5 6
Feelings of extreme bursts of energy	1 2 3 4 5 6	Low self-esteem	1 2 3 4 5 6
Feeling irritable	1 2 3 4 5 6	Changes in appetite	1 2 3 4 5 6
Anger/Rage	1 2 3 4 5 6	Weight gain/loss	1 2 3 4 5 6
Difficulty concentrating/focusing	1 2 3 4 5 6	Doing things that are dangerous/risky	1 2 3 4 5 6
Isolating/Spending time alone	1 2 3 4 5 6	Attention Deficit medication:	1 2 3 4 5 6
Shyness/Nervousness	1 2 3 4 5 6	Physical Pain	1 2 3 4 5 6
Loneliness	1 2 3 4 5 6	Questions about sexuality	1 2 3 4 5 6
Racing thoughts	1 2 3 4 5 6	Questions about gender identity	1 2 3 4 5 6
Feeling very afraid/worried	1 2 3 4 5 6	Physical disability	1 2 3 4 5 6
Boredom	1 2 3 4 5 6	Learning disability	1 2 3 4 5 6
Confusion	1 2 3 4 5 6	Alcohol Use # drinks/wk:	1 2 3 4 5 6
Can't fall sleep/can't stay asleep	1 2 3 4 5 6	Soda/coffee # drinks/wk:	1 2 3 4 5 6
Nightmares	1 2 3 4 5 6	Tobacco # packs/wk:	1 2 3 4 5 6
Low energy/low motivation	1 2 3 4 5 6	Other Drug Use type:	1 2 3 4 5 6
Forgetfulness	1 2 3 4 5 6	Other Drug Use type:	1 2 3 4 5 6

Thinking negative thoughts	1 2 3 4 5 6	Getting used to living in the US	1 2 3 4 5 6
Talking more than usual	1 2 3 4 5 6	Parents Separation/Divorce	1 2 3 4 5 6
Panic attacks	1 2 3 4 5 6	Girlfriend/Boyfriend Relationship Issue	1 2 3 4 5 6
Saying or doing things impulsively	1 2 3 4 5 6	Problems with friends	1 2 3 4 5 6
Can’t get thoughts or ideas out of my head	1 2 3 4 5 6	Worrying about or taking care of parent(s)	1 2 3 4 5 6

Client Name ______________________________________

Please rate the following according to the degree to which they are a challenge in your current life (*If you have questions about any of these items, please ask)*: **1=not a problem at all 2= rarely a problem 3=somewhat of a problem 4= a problem 5= a pretty big problem 6= extreme problem**			
Forcing Throw Up/Eating a Whole Lot	1 2 3 4 5 6	Problems getting along with parent(s)	1 2 3 4 5 6
Feeling Guilty	1 2 3 4 5 6	Difficulty getting homework done	1 2 3 4 5 6
Feeling Stressed	1 2 3 4 5 6	Problems at school	1 2 3 4 5 6
Needing to have things be perfect	1 2 3 4 5 6	Being bullied/pressured/threatened	1 2 3 4 5 6
Acting violently or aggressively	1 2 3 4 5 6	Bullying, threatening others	1 2 3 4 5 6
Cutting/burning/pinching myself	1 2 3 4 5 6	Being cruel to animals	1 2 3 4 5 6
Thoughts about hurting or killing myself	1 2 3 4 5 6	Targeted by racism, classism, heterosexism, ableism, and/or other oppression(s)	1 2 3 4 5 6
Past Attempt to Kill Myself	No/ Yes		

What you have tried or are you trying now to make any of the above problems better? ____________________

How do you feel about becoming involved in counseling? ____________________

Briefly state your goals for counseling: ____________________

If "everything were better" in your life, what would that look like? ____________________

Thank you for taking the time to share this information!