



Oasis Counseling Center

Student Services

Welcome to the Oasis counseling center at Cairn University. We provide students and community members with professional and pastoral counseling to promote emotional, relational, psychological, and spiritual health. The following information will help you to understand how we work. If you still have questions after reading this, we'd be happy to answer them.

YOUR FIRST VISIT

During your first visit, we will collect information from you that will help us to select the right counselor for you. Please provide as much information as possible. All of our counselors are Christians who, at a minimum, have received master's level training in counseling or a related discipline. Whenever possible, we will try to accommodate your preference for a male or female counselor.

COUNSELING SESSIONS

Plan to meet weekly with your assigned counselor at a set day and time. Each session will be 45-50 minutes in duration. Services are provided by professional counselors and by advanced graduate interns in counseling. Senior staff supervises all graduate students providing services at the Oasis Counseling Center. Your counselor is either licensed or being supervised by someone who is licensed. As standard practice, all counselors will identify their licensure status and the names of any clinical supervisors at the Oasis Center. Clients may at any time ask to see a supervisor or the clinical director of the Center for a consultation. We want your counseling experience to be meaningful for you. If for any reason, you are dissatisfied with our services, please let your counselor know. If you are not able to resolve your concerns with your counselor, you may call Ashlyn Jones, Coordinator at 215-702-4304 ext. 4304

REFERRALS

At times, it may become necessary for us to refer you to another professional such as a general practitioner or a psychiatrist. Should this happen, please know that it is because we are committed to implementing best care practices and to the client's best interests.

CONFIDENTIALITY

We understand your need for privacy and will do everything in our power to protect it. Violations of Community Life Standards will not be reported to Student Life or others. Your information can only be released when permitted by you or mandated by law (see confidentiality policy).

CANCELLATION

If you are unable to keep an appointment, please notify us 24 hours in advance by calling 215-702-4224 or by emailing oasis@cairn.edu. If you don't show up for an appointment or you fail to give us sufficient notice, you will risk losing your day and time for future sessions.

EMERGENCY

Should you need to speak with someone in between sessions, call Dr. Jeffrey Black at 267-243-5008. If you are feeling like you might harm yourself or someone else or you otherwise need emergency attention, you can immediately call (911) or go to your nearest hospital emergency room for care. Additionally, Lenape Valley Crisis Intervention Services can be reached at 215-785-9765.

COST OF SERVICES

Registered students of Cairn University have the cost of counseling covered through the semester student services fee. Non-student counselees from the community are required to provide payment of \$25.00 per session at the time services are rendered. Payments can be made with cash or a check made out to Cairn University. Credit/Debit cards are not accepted and we do not bill insurance companies.

CAMERAS

You will notice video/audio recording equipment in some of the counseling offices. These are used to assist in providing your counselor with professional clinical supervision. From time to time a member of the clinical supervision team including interns-in-training may observe your counseling session. This is done to ensure the highest level of care to you. If you have any concerns about this you may discuss this with your counselor.

OASIS COUNSELING CENTER
CLIENT INTAKE FORM

DIRECTIONS: Please complete the following form and bring with you to your first appointment. If you do not complete this form prior to your initial appointment, **your appointment may need to be rescheduled.** Completion of this form is not mandatory in order to be seen at the Counseling Center, but doing so will enable us to provide you with more comprehensive and timely service. ***ALL INFORMATION IS CONFIDENTIAL!***

Date: _____ ID#: _____ Referred by: _____

Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____

City State Zip

Phone: (Cell) _____ (May we call or leave a message at this number?) Y___ N___

(Home) _____ (May we call or leave a message at this number?) Y___ N___

E-mail Address: _____ (May we e-mail you?) Y___ N___

(Note: Because e-mail is not confidential, we strongly discourage you from using e-mail to communicate sensitive information with your counselor.)

Roommates(s): (1) _____ (2) _____

(3) _____ (4) _____

Employment: _____ Hrs. per week: _____

ACADEMIC INFORMATION:

Classification: _____ Hours attempted this semester: _____ Overall GPA: _____

Expected Date of Graduation: _____ Major: _____

Probable Occupation: _____

Relationship Status: Single Dating Engaged Married Divorced

Local Church: _____ Home Church: _____

What brings you to counseling?

How severe do you believe this problem is?

Mildly Upsetting Very Upsetting Urgent, I'm in crisis

How would you rate the level of emotional pain you are currently experiencing?

Mild Moderate Extreme
1 2 3 4 5 6 7 8 9 10

Have you ever sought counseling before? Yes No

If so, please explain:

When? _____ Where? _____ Why? _____

When? _____ Where? _____ Why? _____

Are you currently experiencing any suicidal thoughts? Yes No

If Yes, please explain:

Rate overall risk of suicide

Extremely low risk: 1 2 3 4 5 : Extremely high risk
(will not kill self) (will kill self)

Have you ever experienced suicidal thoughts/actions in the past? Yes No

If Yes, please explain:

How would you assess your current physical health?

Very Good Good Fair Poor

Explain:

How often do you exercise?

Describe your sleeping patterns:

How often do you eat?

How much caffeine do you take in per day? _____

Are you currently taking any prescription medication? Yes No

Name _____ prescribed for _____ Dosage (mg./day) _____

Name _____ prescribed for _____ Dosage (mg./day) _____

Name _____ prescribed for _____ Dosage (mg./day) _____

Have you ever had Surgery? Yes No

If Yes, When and what for?

Do you have a history of alcohol or drug use? Yes No

If Yes, please explain:

Treatment?

FAMILY HISTORY: (Check any that are/were present in your family.)

Who in your family has experienced:

___ Depression _____

___ Anxiety _____

___ Substance Abuse _____

___ Suicide Attempt _____

___ Physical Abuse _____

___ Sexual Abuse _____

___ Eating Disorder _____

___ Other Psychiatric/Emotional Disturbance (explain) _____

___ None

Please check any of the following concerns you are currently experiencing or have experienced:

Present Past

_____ Anxiety

_____ Depression

_____ Bipolar disorder

_____ Unwanted sexual experience

_____ Sleep disturbance

_____ Changes in appetite

_____ Academic problem

_____ Relationship concerns (e.g. break up, conflict)

_____ Relationship violence (e.g. emotional, physical, sexual, verbal abuse)

_____ Panic attacks

_____ Shyness or Social Anxiety

- _____ Test Anxiety
- _____ Obsessive compulsive behavior
- _____ Phobia
- _____ Stress
- _____ Thoughts of suicide
- _____ Suicide attempt(s)
- _____ Self-Injury (e.g. cutting, burning, banging head, etc.)
- _____ Difficulty concentrating
- _____ ADHD
- _____ Low motivation or energy
- _____ Severe mood swings
- _____ Loneliness
- _____ Anorexia
- _____ Bulimia
- _____ Disordered eating
- _____ Anger management
- _____ Family concerns
- _____ Traumatic event
- _____ Physical abuse
- _____ Sexual abuse
- _____ Pornography use
- _____ Gambling
- _____ Recent death or loss
- _____ Legal/Judicial Affairs problem
- _____ Alcohol abuse
- _____ Marijuana use
- _____ Other drugs (e.g. methamphetamine, cocaine, etc.)
- _____ Sexual dysfunction
- _____ Health concern
- _____ Work-related concern
- _____ Identity problem
- _____ Religious or spiritual problem
- _____ Cultural concerns
- _____ Excessive video or online game use
- _____ Other: _____

What do you see as your top 5 **strengths**?

1. _____ 2. _____ 3. _____
 4. _____ 5. _____

What do you do for self-care (i.e. hobbies, interests, etc.)?

Have you experienced any of the following types of abuse or exploitation?

- Physical
- Emotional
- Sexual
- Rape/date rape

Parents Marital Status:

- Single, Never married
- Married (how long? _____)
- Divorced (how long? _____)
- Separated (how long? _____)
- Widowed (how long? _____)

Do you prefer to speak with a: Male Counselor Female Counselor Either

What is your availability?

	Mon	Tue	Wed	Thur	Fri	Sat
Morning						
Afternoon						
Evening						

Please indicate the service(s) you are interested in exploring during the triage appointment:

- ___ Self-help materials
- ___ Brief problem-solving (1-2 sessions)
- ___ Individual counseling, short (1-4 sessions)
- ___ Individual counseling (4-12 sessions)
- ___ Long-term individual counseling
- ___ Group counseling
- ___ Referral to other appropriate services
- ___ Psychiatric assessment and services
- ___ Dietitian assessment and services

What is your Goal for counseling?

At the present time, how well do you feel you are getting along emotionally, mentally and physically?

- Very poorly: I can barely manage to deal with things.
- Fairly poorly: life is pretty tough for me at times.
- So-so: I manage to keep going with some effort.
- Pretty well: I have my ups and downs, but I generally manage to do okay.
- Very well: much the way I would like to be.

Please use the remaining space on the back of this page to provide any additional information.

THANK YOU!! If you received this form via email **please print this form and bring to your initial appointment.** You and your intake counselor will determine the most appropriate therapeutic service for your particular concern. Options include: **Individual Counseling, Group Counseling, Couple's Counseling, and Referral to the Community.**

INFORMED CONSENT/COUNSELING SERVICES AGREEMENT

CONFIDENTIALITY POLICY

All counseling communications, records, and contacts between you and your counselor will be held in confidence, and will be discussed only with the Director of Counseling Services and supervising team for case management purposes. Counseling sessions may be periodically viewed or recorded by Oasis team members and supervisors for counselor-training purposes. Violations to CU's Community Life Standards **will not** be reported to Student Life or others. Exceptions to this confidentiality policy may occur only under the following conditions:

1. You sign a written release for your counselor to release information to another person or agency.
2. You express serious intent to harm yourself or someone else.
3. Reasonable indication arises during counseling of abuse of a minor child, elderly person or dependent adult.
4. A court order is received mandating disclosure of information.

Other than these possibilities your treatment, history and personal information will not be disclosed without your full knowledge and a signed release of information.

I have read and understand this paragraph_____ (initial)

AUDIO/VISUAL CONSENT

I, _____, understand that my counselor is involved in internship training and/or a staff counselor at Oasis Counseling Center. I understand that Oasis is a training facility where my sessions have the possibility of being recorded for quality assurance and training purposes. As a training facility it will be expected that sessions be recorded. I understand that quality counseling is achieved through quality supervision.

I understand that all information shared will be held in strict confidence and restricted to supervision. **If used in any other setting a separate consent agreement will be signed.** I understand that all audiotapes and videotapes will be destroyed in a timely fashion.

I have read and understand this paragraph_____ (initial)

SUPERVISION AGREEMENT

Oasis Counseling Center is a training facility that employs interns and part time staff counselors. My counselor (both interns and staff counselors) have made me aware that they are meeting for supervision with a licensed supervisor to ensure best care practices. I have been advised that my counseling may be reviewed in these sessions; however, both counselor and supervisors are held to the same practice and adherence of professional and ethical guidelines and will always keep my information confidential.

I have read and understand this paragraph_____ (initial)

COUNSELING SESSIONS

A counseling session is generally 45-50 minutes and typically scheduled on a weekly basis. If you are unable to keep your appointment, please email or call to cancel or reschedule at least 24 hours prior to the appointment. If you routinely miss appointments or do not give notice you will risk losing your time slot with your counselor.

The duration of counseling varies. Some individuals require a shorter time to meet their goals while others require counseling over an extended period of time. Counseling requires effort on your part and the commitment to change inside and outside of sessions. This includes efforts to change thoughts, feelings, and behaviors. There will be homework such as writing, journaling, and other assignments. Sometimes change will be achieved quickly but, for the most part, it will be slow and deliberate. Remember that change often requires practice and repetition.

Please note: It is impossible to *guarantee* specific results from the goals we set together. You have the right at any time to discuss with the counselor goals of counseling and methods of achieving these goals. We will periodically evaluate progress and, if necessary, rewrite the treatment plan (goals and methods). We will work to **achieve the best possible results for you**. Ending therapy is often mutually planned, however; you may stop at any time.

Counseling is a powerful intervention and, as such, it has both benefits and risks. You may acquire benefits such as change, a new outlook and a healthier life; you may take risks that produce uncomfortable levels of feelings like sadness, guilt, anxiety, anger, or difficulties with people, before you feel better. Circumstances may worsen and you may experience losses, for example, therapy will not necessarily keep a marriage intact.

I enter this relationship with you with anticipation. You and I will have a professional relationship, that is, we will work together in sessions and we will not have social connections. Although you will learn about me in session, our primary focus is on your concerns.

I have read and understand this section _____(initial)

(Client, Parent/Guardian)

Date _____

(Counselor)

Date _____