Oasis Counseling Center

Intake form

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete the form as honestly and completely as possible. Once completed, you may scan it and email it to oasis@cairn.edu or bring the physical copy to the Oasis Counseling Center. All information that you provide will be confidential as required by state and federal law.

Date: _____

Name: _____ **Date of Birth**: _____ **Age**: _____

Home Address: _____ **City/State/Zip code**: _____

Home Phone: _____ **Cellular/Alternate Phone**: _____

Email Address: _____

Marital Status: single dating engaged married remarried
separated divorced widowed living together

In your own words, describe the current problems as you see them:

_____
_____
_____
_____

How long has this been going on? _____

What made you go for counseling at this time? _____

_____
_____

What do you hope that we can accomplish together?

_____
_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____
_____

SYMPTOMS

Please check any symptoms or experiences that you have had in the last several months:

☐Difficulty falling asleep
☐Difficulty staying asleep
☐Difficulty getting out of bed
☐Not feeling rested in the morning
☐Inconsistent sleep routines
☐Difficulty getting to sleep after waking in the middle of the night

Average hours of sleep per night: _____

☐Withdrawing from other people ☐Spending increased time alone
☐Depressed mood ☐Rapid mood changes
☐Irritability ☐Panic attacks
☐Frequent feelings of guilt ☐Avoiding people, places, activities, or specific things
☐Difficulty leaving your home (dorm) ☐Outbursts of anger
☐Persistent loss of interest in previously enjoyed activities
☐Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
☐Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)

☐Feelings of worthlessness ☐Feelings of hopelessness
☐ Feelings of sadness ☐Feelings of helplessness
☐ Feeling fearful ☐Feeling or acting like a different person
☐Feeling intense or persistent shame ☐Grief or deep feelings of loss
☐Feelings of guilt ☐Feeling isolated or lonely
☐Feeling shy ☐Not being able to stop or control worrying
☐Racing thoughts

☐Changes in eating/appetite ☐Eating more or binge eating
☐Voluntary vomiting (purging) ☐Eating significantly less than normal
☐Use of laxatives ☐Excessive exercise to avoid weight gain
☐Intense fear of gaining weight or becoming fat ☐ A sense of lack of control over eating
☐Intense dissatisfaction with body weight or shape

☐Difficulty catching your breath ☐Increased muscle tension – muscles feel tight and tense
☐Unusual sweating (not due to heat/exertion) ☐Easily startled, feeling "jumpy"
☐Increased energy ☐Fatigue, low energy, decreased energy
☐Physical sensations others don't have ☐Light headedness or dizziness that come on suddenly
☐Crying spells ☐Being so restless that it's hard to sit still
☐Trouble relaxing ☐Hands trembling
☐Fainting ☐Numbness or tingling
☐Heart pounding or racing ☐Feeling unsteady
☐Difficulty calming down once I get upset ☐Feeling out of control emotionally

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☐Intrusive memories ☐Feelings of detachment or estrangement from others
☐Difficulty remembering things ☐Difficulty concentrating or thinking
☐Flashbacks ☐Nightmares
☐Reckless or self-destructive behavior ☐Hypervigilance
☐Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

☐Lose track of time when interacting on social media ☐Excessive time spent on social media or video gaming sites

☐Experienced or witnessed child abuse: childhood neglect, physical violence, sexual abuse, sexual violence
☐Experienced abuse in the workplace
☐Experienced spiritual abuse
☐Thoughts about harming / killing yourself
☐Experienced bullying or harassment
☐Thoughts about harming someone else

☐Feeling puzzled as to what is real and unreal
☐Persistent, repetitive, intrusive thoughts, impulses, or images
☐Hearing voices when no one else is present
☐Unusual visual experiences such as flashes of light, shadows
☐Feeling that your thoughts are controlled by someone else or placed in your mind by someone else
☐Feeling like the television or your computer is communicating with you

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☐Difficulty problem solving
☐Difficulty meeting role expectations
☐Dependency on others
☐Tendency to manipulate others when fulfilling your desires
☐Inappropriate expression of anger
☐Self-injury (for example, cutting)
☐Ineffective communication
☐Being easily influenced by others
☐Difficulty or inability to say "no" to others
☐Being talked into doing something that you really didn't want to do
☐Feeling abandoned by people
☐Trouble getting along with people at work/school/home
☐General discomfort in social situations
☐Feeling awkward around people you don't know well
☐Difficulty getting along with people
☐Often feeling misunderstood
☐Decreased ability to handle stress
☐Feeling like you don't have control of your relationships
☐Have you ever been in an abusive relationship?
☐Difficulty expressing emotions
☐Concerns about your sexuality
☐Not feeling content with who you are
☐Often act without thinking
☐Often feel bored

☐Difficulty in looking forward to the future with hope and enthusiasm
☐Confusion about what you want in life
☐Feeling like giving up because there is nothing that you can do to feel better for yourself
☐Admiring someone and then being very disappointed in them
☐Hurting myself as a way to get rid of upsetting feelings or thoughts
☐Feeling like I don't understand why I make the choices I make
☐Feeling like I don't really know who I am
☐Feeling afraid that someone you care about might leave you
☐Feeling empty or angry when people walk away from you
☐Feeling very upset when someone criticizes you

☐Have difficulty explaining things in their proper order or sequence
☐I don't seem to process information as quickly or as accurately as others
☐Have trouble learning new or complex activities as well as others
☐Unable to "think on my feet" or respond as effectively as others to unexpected events
☐Unable to come up with or invent as many solutions to problems as others seem to do
☐I am slower than others at solving problems I encounter in my daily life
☐Find myself at a loss for words when I want to explain something to others

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☐Waste or mismanage my time

☐Poor sense of time

☐Have trouble doing what I tell myself to do

☐Have difficulty motivating myself to stick with my work and get it done

☐Can't seem to get things done unless there is an immediate deadline

☐Not motivated to prepare things in advance for things I know I am supposed to do

☐Procrastinate or put of doing things until the last minute

☐Make impulsive comments to others ☐Make decisions impulsively

☐Unable to inhibit my reactions or responses to events or others

☐Likely to do things without considering the consequences for doing them

☐Don't think about or talk things over with myself before doing them

☐Have difficulty stopping my activities or behavior when I should do so

☐Fail to consider past relevant events or past personal experiences before responding to situations (I act without thinking)

☐ I remain emotional or upset longer than others

☐Cannot seem to regain emotional control and become more reasonable once I am emotional

☐Cannot seem to distract myself away from whatever is upsetting me emotionally to help calm me down. I can't refocus my mind to a more positive framework.

☐Have trouble calming myself down once I am emotionally upset

☐ I find it difficult to walk away from emotionally upsetting encounters with others or leave situations in which I have become very emotional

☐ I cannot rechannel or redirect my emotions into more positive ways or outlets when I get upset

☐ I am not able to evaluate an emotionally upsetting event more objectively

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☐Procrastinate or put off doing things until the last minute

☐Have trouble planning ahead or preparing for upcoming events

☐Have difficulty motivating myself to stick with my work and get it done

☐Have trouble completing one activity before starting into a new one

☐ I have trouble organizing my thoughts

☐Have difficulty stopping my activities or behavior when I should do so

☐Have difficulty changing my behavior when I am given feedback about my mistakes

☐Not aware of things I say or do

☐More likely to drive a motor vehicle much faster than others (excessive speeding)

☐Likely to take short cuts in my work and not do all that I am supposed to do

☐Have to depend on others to help me get my work done

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?
No | Yes | If so:

Name of therapist: _____ Dates of Treatment: _____
Reason for seeking help: _____

Name of therapist: _____ Dates of Treatment: _____
Reason for seeking help: _____

Have you been on **PSYCHIATRIC** medication in the **PAST**? No | Yes | If YES, please list:

Medication	Dosage	First time / Last time you took it	Effect of medication

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? No | Yes | If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Have you been hospitalized for psychiatric reasons? No | Yes | If YES, describe:

Hospital	Dates	Reason

Have you ever attempted suicide? No | Yes | If YES, describe:
_____
_____
_____

MEDICAL HISTORY

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? No | Yes | If YES, please list:

Medication	Dosage	How long have you been taking it?

Have you ever lost consciousness? No | Yes | If YES, please explain:
_____
_____

Are you **CURRENTLY** taking medication to treat a medical condition? No | Yes | If YES, describe:

_____

_____

_____

List any PRIOR illnesses, surgeries, and accidents:

_____

FAMILY HISTORY

Father: Age: ____ | Living | Deceased | Cause of death: _____

If deceased, HIS age at the time of his death: _____ YOUR age at the time of his death: _____
Occupation: _____ His health: _____
Frequency of contact with him: _____ Are you / Have you been close to him? _____

Mother: Age: ____ | Living | Deceased | Cause of death: _____

If deceased, her age at the time of his death: _____ YOUR age at the time of her death: _____
Occupation: _____ Her health: _____
Frequency of contact with her: _____ Are you / Have you been close to her? _____

Siblings and stepsiblings:

Name	Sex	Age	Whereabouts	Are you close to him/her?	
				No	**Yes**
				No	**Yes**
				No	**Yes**
				No	**Yes**

During your childhood, did you live any significant period of time with anyone other than your biological parents?
No | Yes | If YES, please give the person's name and relationship to you:
Name: _____ Relationship to you: _____

SOCIAL HISTORY

Past Marital History
Have you been married previously? No | Yes | If YES, please describe:
When? _____ How long? _____
When? _____ How long? _____

If applicable, please complete the following:
Partner's Name: _____ Partner's Age: _____
Partner's Occupation: _____

IF YOU HAVE CHILDREN, PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

Education

Highest grade level completed: _____

Degree obtained, if applicable: _____

Have you served in the military? No | Yes

If YES, please describe briefly: _____

Employment

Are you currently employed? No | Yes If YES, employer's name: _____

What type of work do you do? _____

Employment History (most recent first):

Type of Job	Dates	Reason for Leaving

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? No | Yes | If YES, age of first use: _____

How much do you drink? _____ How often? _____

Have you ever passed out from drinking? _____ How often? _____

Have you ever blacked out from drinking? _____ How often? _____

Have you ever had the "shakes"? _____ How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use? _____

Have you ever felt bad or guilty about your drinking/drug use? _____

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? _____

Do you use tobacco? No | Yes | If YES, how often? _____

Other Drugs

Please indicate for each drug listed below:

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

THANK YOU!! If you received this form via email, **please scan and email to oasis@cairn.edu prior to your first appointment.** Our office staff will schedule you for an appointment with an Oasis Center counselor.