



Oasis Counseling Center

Student 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: _____ Referred by: _____

Name: _____ Date of Birth: _____ Age: _____

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

Home Phone: _____ Cellular/Alternate Phone: _____

Email Address: _____

University address: _____

Roommates: _____

ACADEMIC INFORMATION:

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

Major: _____ Expected Date of Graduation: _____

Probable Occupation: _____

Local church: _____ Home church: _____

Pastor's name: _____ Pastor's name: _____

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:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Difficulty getting out of bed | <input type="checkbox"/> Not feeling rested in the morning |
| <input type="checkbox"/> Inconsistent sleep routines | <input type="checkbox"/> Difficulty getting to sleep after waking in the middle of the night |
- Average hours of sleep per night: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Feelings of hopelessness |
| <input type="checkbox"/> Feelings of sadness | <input type="checkbox"/> Feelings of helplessness |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Feeling or acting like a different person |
| <input type="checkbox"/> Feeling intense or persistent shame | <input type="checkbox"/> Grief or deep feelings of loss |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Feeling isolated or lonely |
| <input type="checkbox"/> Feeling shy | <input type="checkbox"/> Not being able to stop or control worrying |
| <input type="checkbox"/> Racing thoughts | |

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

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

- | | |
|---|---|
| <input type="checkbox"/> Intrusive memories | <input type="checkbox"/> Feelings of detachment or estrangement from others |
|---|---|

- Difficulty remembering things
- Flashbacks
- Reckless or self-destructive behavior
- Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)
- Difficulty concentrating or thinking
- Nightmares
- Hypervigilance

- 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
- Thoughts about harming / killing yourself
- Thoughts about harming someone else
- Experienced spiritual abuse
- Experienced bullying or harassment

- Feeling puzzled as to what is real and unreal
- Hearing voices when no one else is present
- 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
- Persistent, repetitive, intrusive thoughts, impulses, or images
- Unusual visual experiences such as flashes of light, shadows

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

- 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 off 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
-

- 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 provide the person's 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 osis@cairn.edu prior to your first appointment. Our office staff will schedule you for an appointment with an Oasis Center counselor.