Oasis Counseling and Educational Services
New Client Information

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

Current Date _____

Name _____ Sex ❒Male ❒Female

Previous Name _____ Age _____

Date of birth _____/_____/_____ Social Security Number_____-_____-_____

Address _____ City/State/Zip _____

Home # _____-_____-_____ Work # _____-_____-_____ Cell # _____-_____-_____

Best Time / Place to call ❒Home ❒Work ❒ Cell ❒ a.m. ❒ p.m.

Emergency Contact Name _____ Phone # _____-_____-_____

Employer _____ Hire Date _____ Position _____

Check last year of school completed: ❒9 ❒10 ❒11 ❒12 ❒GED College ❒1 ❒2 ❒3 ❒4 ❒Other_____

If full time student, School _____ City _____ Phone #_____-_____-_____

Religion _____ Church _____ Pastor _____

Who referred you to Oasis Counseling? _____

❒E.A.P. or ❒INSURANCE

Primary Insured Name _____ Date of Birth _____/_____/_____

Social Security Number _____-____-_____ Relationship to client ❒Self ❒Spouse ❒Child

Address _____ Zip _____

Phone Numbers Home _____-_____-_____ Work _____-_____-_____ Cell _____-_____-_____

If client is a *minor,* state the relationship to the primary insured ❒Father ❒Mother ❒other _____

Employer & address _____

Name of E.A.P. or Insurance Provider _____ Member ID # _____

Group # _____ Phone # to verify coverage (Mental Health Outpatient) _____

Marital Status: ❒Single (Never Married) ❒Engaged ❒Married ❒Living Together (Not Married) ❒Separated ❒Divorced

Separated how long? _____ Divorced how long? _____ Widowed how long? _____

How long have you been married to this spouse? _____ Are you happy in this marriage? _____

If no, please provide an explanation: _____

_____

Total number of marriages for you_____ For your Spouse _____

List Child/ Children Information Below:

Child name	Age	Sex	Relationship to you	Live in home

List other person (s) living in your home:

Name	Age	Sex	Relationship to you	Live in your home?

Medical Information

Primary care Physician_____ Phone Number _____

Psychiatrist_____ Phone Number _____

List your current medications:

Medication name	Dosage	Reason for taking this medication

List any allergies you have_____

Describe your physical health: ❒Excellent ❒Good ❒Adequate ❒Poor

Have you ever been hospitalized for any mental illness or substance abuse? ❒Yes ❒No How long ago? _____

Reason_____ Hospital _____ City_____

Did you continue with outpatient counseling? ❒ Yes ❒No

Name of Counselor_____ Phone number_____

Family members under care, list below:

Name of family member_____ Nature of treatment_____

Name of family member_____ Nature of treatment_____

Is there any history of the following illnesses in the family, state relationship to you:

❒Emotional problems_____ ❒Heart disease_____ ❒ Schizophrenia_____

❒Behavioral problems_____ ❒Cancer_____ ❒Alzheimer's/Dementia_____

❒Alcoholism_____ ❒High Blood Pressure_____ ❒Tuberculosis_____

❒Drug Abuse_____ ❒Birth defects_____ ❒Thyroid problems_____

❒Bi-polar_____ ❒Mental Retardation_____ ❒Other chronic or serious problems_____

Developmental History (check all that apply):

❒feeding self ❒tolerating separation ❒fire-setting ❒bizarre behavior ❒ poor concentration ❒speaking with words
❒animal cruelty ❒speaking sentences ❒ playing cooperatively ❒hyperactive ❒self- injurious threats ❒breaks things
❒controlling bladder ❒riding tricycle ❒riding bicycle ❒assaults others ❒disobedient ❒frequently daydreams
❒often sad ❒lack of attachment ❒other _____

Social Interaction (check all that apply):

❒normal social interaction ❒inappropriate sex play
❒isolates self ❒dominates others
❒very shy ❒associates with acting out peers
❒alienates self ❒other_____

Intellectual / academic functioning (check all that apply):

❒normal intelligence ❒authority conflicts ❒mild retardation
❒high intelligence ❒attention problems ❒moderate retardation
❒learning problems ❒underachieving ❒severe retardation
❒current or highest education level_____

Describe any other developmental problems or issues: _____
_____
_____

SOCIO-ECONOMIC HISTORY

General Symptoms of Chemical Dependency (check all that apply for patient)

Living Situation:
❒housing adequate
❒homeless
❒housing overcrowded
❒dependent on others –housing
❒housing dangerous/deteriorating
❒living companions dysfunctional

Social support system
❒supportive network
❒few friends
❒substance use based friends
❒no friends
❒distant from daily origin

Sexual history
❒heterosexual orientation ❒currently sexually dissatisfied
❒homosexual orientation ❒currently sexually satisfied
❒bisexual orientation
❒currently sexually active: Age of first sexual exp ___
Age of first pregnancy / fatherhood____
❒history of promiscuity age ___to___
❒history of unsafe sex age ___to___

Additional information: _____

Employment:
❒Employed & satisfied
❒Employed but dissatisfied
❒unemployed
❒coworker conflicts
❒supervisor issues
❒unstable work history
❒disabled:_____

Financial Situation:
❒no current problems
❒large indebtedness
❒poverty or below poverty
❒impulsive spending
❒relationship conflicts over finances

Military History:
❒never in military
❒served in military-no incident
❒served in military w/ incident
❒other: _____
_____

Legal History:
❒no legal problems
❒on parole/probation
❒arrest (s) not substance related
❒arrest (s) substance related
❒court ordered this treatment
❒jail /prison _____time (s)
total time served: _____
describe last legal difficulty:_____

Cultural/ Spiritual/ recreational History:
Cultural identity (ethnicity, religion): _____
_____
_____
Describe any cultural issues that contribute to current problem:
_____
Currently active in community/recreational activities: ❒Yes ❒No
Formerly active in community/recreational activities: ❒Yes ❒No
Currently engaged in hobbies? ❒Yes ❒No
Currently participating in spiritual activities? ❒Yes ❒No
If you answered "yes" to any of the questions above, please describe: _____
_____
_____

Substance Abuse/Chemical Use History

❒Loss of control ❒A.M. drinking ❒Hiding Supply ❒Prescription abuse ❒Blackouts ❒Pre-drinking
❒Sneaking use ❒Use to reward self ❒Unable to stop ❒Use to reduce stress ❒Tolerance ❒Guilt or remorse
❒Tremors ❒High Blood Pressure ❒Hepatitis ❒Seizures ❒Ulcers ❒Nosebleeds
❒Gastritis ❒Delirium ❒Other symptoms, elaborate (including trigger events): _____
_____

Behavior – Personality Changes associated with use

❒Verbal abuse ❒Social isolation ❒Insomnia ❒Physical abuse ❒Labile mood ❒Family concerned
❒Excessive anger ❒Un-kept promises ❒Work Concerned ❒Sexual performance ❒More relaxed mood
❒Depression ❒Embarrassed by behavior after use ❒More/less social ❒Effects on morality or spirituality
❒Other symptoms, please elaborate (including trigger events) _____
_____

Other Addictions

❒Eating ❒Gambling ❒Sexual ❒Diets ❒Spending ❒Codependency ❒Other_____

Treatment History

❒Detoxification: _____ ❒Outpatient: _____ ❒After care: _____
❒Other: _____ ❒Inpatient _____ ❒ Longest abstinence: _____

Problems in Job, School, Home, or Other Role Functions

❒Suspended License ❒Disciplined ❒Using at work/school ❒Wages garnished ❒Erratic behavior ❒Attendance
❒Promises to improve ❒Accidents/ safety violations ❒Argumentative

Counseling History

Date of or last counseling session _____ ❒alone ❒ with spouse ❒with child/children ❒family

Current problem(s) or concern(s): lease list how long you have had the problem (s) or concern (s):
1.) _____

_____

2.) _____

_____

3.) _____

_____

What have you done or are currently doing to resolve the problem (s) or concern (s)?

1.) _____

_____

2.) _____

_____

3.) _____

_____

What are your therapy goals?
1.) _____

_____

2.) _____

_____

3.) _____

_____