Oasis Family Services CLIENT INTAKE FORM

The following intake form is to be filled out by all new clients. You‘re welcome to print the paper version of this form and bring it with you to your intake appointment. The answers you provide will become part of your confidential mental health records. Please DO NOT send the completed form via email.

Date: ___/___/___

First Name ____________________ Last Name _________________________

Soc. Sec. #________________________________ Date of Birth______________

Address ___________________________________ Apt # _________

City _____________________________ State _____ Zip _______ + _____

Primary Phone __________________ Ext. _____ Work Phone ____________________ Ext. _____

Cell Phone ______________________ Email Address _________________________________

Employer ______________________________

Have you had any previous mental health treatment: Yes No

Are you currently (or in the recent past) taking any prescription or over the counter medications? :
Yes No
If yes, please give details.

Does anyone else in your family (blood relatives) suffer from any mental illness? Yes No
If yes, please give details:

Do you drink alcohol? Yes No.
If yes, please give details – how much, how often, any blackouts, etc.

Do you use any other recreational drugs? Yes No.
If yes, please give details – what drugs, how often, last use etc

Have you ever suffered from any type of eating disorder? Yes No.
If yes, please give details:

Have you ever been charged with a crime, arrested or convicted? Yes No
If yes, please give details:

Do you have any work-related problems or difficulties in school? Yes No.
If yes, please give details

Do you have a history of trauma (any kind of abuse, neglect, victim of natural or other disaster etc)?
Yes No.
If yes, please give details:

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Symptoms Checklist:

Sleep: No problems Not enough Trouble getting up Nightmares Too much sleep

Appetite: No problems No interest Increased appetite Carbohydrate craving

Energy: Normal Increased Low Up and down

Interest in Sex: Normal Increased Low

Concentration: Normal Somewhat difficult Poor Terrible

Memory: Good Some difficulty remembering Poor

Depressed or sad: All the time Most days Some days Not at all

Suicidal thoughts: All the time Most days Some days Not at all

Past suicidal attempts: No Yes
If yes, please give details:

Anxiety: Panic attacks All the time Most days Some days Not at all

Anger/Irritation: All the time Most days Some days Not at all

Any other Comments :

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