Options
Counseling and Family Services

Appointment Date: _____ Client #:_____

Client Intake Sheet

Date: _____

Client Information:

Client Name Last: _____ First: _____ Middle: _____

Preferred Name: _____ Birth/Maiden Name: _____

Birth Gender: ☐ Male ☐ Female ☐ Other _____

Gender Identity: ☐ Identifies as Male ☐ Identifies as Female ☐ Female-to-Male ☐ Male-to-Female ☐ Genderqueer (neither male nor female) ☐ Choose not to disclose ☐ Other _____

Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other _____

Sexual Orientaion: ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Other _____ ☐ Don't know ☐ Choose not to disclose

Date of Birth: _____ Social Security: _____-_____-_____

Primary Language: _____ **Interpreter Needed?** ☐ Language ☐ ASL

Primary Phone Number: _____
Type of Phone: ☐ Home ☐ Cell ☐ Work
Okay to receive appt. reminder texts: ☐ Yes ☐ No
Okay to use Options' name: ☐ Yes ☐ No
Best times to call: _____

Alt. Phone Number: _____
Type of Phone: ☐ Home ☐ Cell ☐ Work
Okay to receive appt. reminder texts: ☐ Yes ☐ No
Okay to use Options' name: ☐ Yes ☐ No
Best times to call: _____

Available for an appointment on Saturday: ☐ Yes ☐ No
Are you a previous Options Client: ☐ Yes ☐ No **Are you a current client at any other agency:** ☐ Yes ☐ No
Has the court recommended treatment: ☐ Yes ☐ No

Physical Address: _____

Mailing Address: _____

Okay to send mail from Options: ☐ Yes ☐ No

If client is a child, please answer the following:

Guardian Name: _____ **Relationship:** _____

Address: _____ Phone Number: _____

Guardian Name: _____ **Relationship:** _____

Address: _____ Phone Number: _____

Siblings:

Name : _____ Age: _____ Name : _____ Age: _____

Name : _____ Age: _____ Name : _____ Age: _____

Teacher: _____ **School:** _____ **Grade:** _____

Emergency Contact:

Name: _____ Phone Number: _____

Okay to ID Options: ☐ Yes ☐ No Okay to use as an alternate contact: ☐ Yes ☐ No

DHS Caseworker (if applicable):

Name: _____ Phone Number:_____

Email: _____ Fax Number: _____

Payment Arrangements:

OHP Number: _____ Effective Date:_____

Private Insurance – please provide information on **any private insurance coverage within the last 12 months**:

Company: _____Policy Holder: _____

Policy/ID Number: _____Group Number: _____

Phone Number: _____Fax Number: _____

I have made other payment arrangements:** ☐ DHS ☐ Voc. Rehab. ☐ Self-Pay ☐ Sliding Scale ☐ Other
(**All payment arrangements are subject to Options Billing Department verification and approval)

Client Support System:

Spouse/Partner:_____Phone: _____

Primary Care Doctor: _____ **Phone:** _____

Clinic Name: _____ Fax:_____

Dental Provider: _____ **Phone:** _____

Clinic Name: _____ Fax:_____

Other Agencies, Caseworkers, or Health Care Providers Involved:

Contact Name: _____**Phone:** _____

Agency/Program: _____Fax: _____

Contact Name: _____**Phone:** _____

Agency/Program: _____Fax: _____

It is the policy of Options Counseling and Family Services to be non-discriminatory in the delivery of services to clients without regard to race, color, religion, national origin, age, gender, disability, source of income, gender identity or expression, and/or sexual orientation.
Options is required to request the following information for Oregon Department of Human Services for the Measures and Outcomes Tracking System (MOTS). This data is collected and used to determine funding levels and effectiveness of mental health programs in our community.

Client Demographic Data:

Race (Please check from the following):

- ☐ White
- ☐ American Indian
- ☐ Black/African American
- ☐ Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/other Pacific Islander
- ☐ Other Single Race
- ☐ Two or More Unspecified Race

Ethnicity (Please check from the following):

- ☐ Not of Hispanic Origin
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Hispanic – No Specific Origin
- ☐ Cuban
- ☐ Unknown
- ☐ Other Specific Hispanic _____

Marital Status (Please check from the following):

☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ I Prefer Not to Respond

Are you a Veteran? ☐ Yes, Current/Former Active Duty Military ☐ Yes, Current/Former Guard/Reserve Military ☐ No, But Current/Former Guard/Reserve Military ☐ No

Tobacco Use (last 90 days): ☐ Yes ☐ No ☐ I Prefer Not to Respond

Substance use in the last 90 days (alcohol or non-prescribed medications)? ☐ Yes ☐ No ☐ I Prefer Not to Respond

Employment Status of the Client (Please check from the following):

- ☐ Full Time (over 35 hours/week)
- ☐ Part Time (under 35 hours/week)
- ☐ Unemployed – Seeking Employment
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Disabled
- ☐ Hospital or Institutional Resident
- ☐ Sheltered/Non-Competitive Employment
- ☐ Not in the Labor Force
- ☐ Other Classification (ex. Volunteers)

Highest Grade Completed: _____ **Are you currently enrolled in school/training?**: ☐ Yes ☐ No

Living Arrangements (Please check from the following): ☐ Other:_____

- ☐ Private Residence
- ☐ Private Residence (at home)
- ☐ Private Residence (with relative)
- ☐ Private Residence (with non-relative)
- ☐ Transient/Homeless
- ☐ Foster Home
- ☐ Jail
- ☐ Residential Facility/Group Home
- ☐ Residential Facility (SUD)
- ☐ Residential Facility (BRS)
- ☐ Residential Facility (CSEC)
- ☐ Residential Facility (PRTS)
- ☐ Residential Facility (SCIP/SAIP)
- ☐ Residential Facility (SRTF -YAT)
- ☐ Secure Residential (SRTF Adult)
- ☐ Residential SubAcute Facility
- ☐ Room & Board-Independent Living Facility
- ☐ Prison
- ☐ Supported Housing – Scattered Site
- ☐ Supported Housing – Congregate Setting
- ☐ Oxford Home
- ☐ Alcohol/Drug Free Housing
- ☐ Supported Housing – Other Type

Estimated *Monthly Household* Income: $ _____ ☐ I Prefer Not to Respond

Primary Source of Income (Please check from the following):

- ☐ Wages/Salary
- ☐ Public Assistance
- ☐ Retirement/Pension SSI
- ☐ Disability/SSDI
- ☐ Other
- ☐ None
- ☐ I Prefer Not to Respond

Dependents (Include the total number of persons, including the client, that are supported by the household income):

- **Adults** (include minors living independently) : # _____
- **Children** (include minors for which child support is paid out of this income): # _____

Referred From – How did you hear about Options?

Local or State Agencies:

- ☐ Child Welfare
- ☐ Vocational Rehabilitation
- ☐ Aging and People with Disabilities
- ☐ Local Mental Health Authority
- ☐ Developmental Disability Services
- ☐ Community Mental Health Program
- ☐ School
- ☐ Community Housing
- ☐ Employment Services

Personal Support System:

- ☐ Self
- ☐ Family/Friend
- ☐ Employee Assistance Program
- ☐ Advocacy Group
- ☐ Attorney

Health Care Providers:

- ☐ Community Substance Abuse Provider
- ☐ Community Mental Health Provider
- ☐ Coordinated Care Organization
- ☐ State Psychiatric Facility
- ☐ Private Health Professional (ex PCP, PHD, Hospital, Health Home)
- ☐ Alcohol/Drug Evaluation Screening Specialist (ADES)

Justice System:

- ☐ Federal Court
- ☐ Circuit Court
- ☐ Justice Court
- ☐ Jail
- ☐ Municipal Court
- ☐ Parole – including Juveniles
- ☐ Police or Sheriff
- ☐ Psychiatric Review Board
- ☐ Probation – including Juveniles
- ☐ State Correctional Institution
- ☐ Federal Correctional Institution
- ☐ Integrated Treatment Court
- ☐ Juvenile Justice System/OYA

Other:

- ☐ Crisis/Helpline
- ☐ Internet/Media
- ☐ Other
- ☐ None
- ☐ I Prefer Not to Respond

Tribal Affiliation (Please check from the following):

- ☐ Not Applicable
- ☐ Burns Paiute Tribe
- ☐ Confederated Tribes of Coos, Lower Umpqua & Siuslaw
- ☐ Confederated Tribes of Grand Ronde
- ☐ Confederated Tribes of Siletz
- ☐ Confederated Tribes of the Umatilla
- ☐ Confederated Tribes of Warm Springs
- ☐ Coquille Indian Tribe
- ☐ Cow Creek Band of Umpqua Indians
- ☐ Klamath Tribes
- ☐ Other _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Not Applicable/Male ☐ I Prefer Not to Respond

---