

Client Intake Sheet

Date: _____

Client Information:

Client Name Last: _____ First: _____ Middle: _____

Preferred Name: _____ Birth/Maiden Name: _____

Gender: Male Female Other _____

Identify as: Male Female Genderqueer (neither male nor female)
 Choose not to disclose Other _____

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

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

Primary Language: _____ Interpreter Needed? Language ASL

Primary Phone Number: _____ 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: _____

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):

- | | | |
|---|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other Single Race |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian | <input type="checkbox"/> Two or More Unspecified Race |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Native Hawaiian/other Pacific Islander | |

Ethnicity (Please check from the following):

- | | | |
|---|--|--|
| <input type="checkbox"/> Not of Hispanic Origin | <input type="checkbox"/> Hispanic - No Specific Origin | <input type="checkbox"/> Other Specific Hispanic _____ |
| <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Cuban | |
| <input type="checkbox"/> Mexican | <input type="checkbox"/> Unknown | |

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):

- | | | |
|--|---|--|
| <input type="checkbox"/> Full Time (over 35 hours/week) | <input type="checkbox"/> Student | <input type="checkbox"/> Sheltered/Non-Competitive Employment |
| <input type="checkbox"/> Part Time (under 35 hours/week) | <input type="checkbox"/> Retired | <input type="checkbox"/> Not in the Labor Force |
| <input type="checkbox"/> Unemployed - Seeking Employment | <input type="checkbox"/> Disabled | <input type="checkbox"/> Other Classification (ex. Volunteers) |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Hospital or Institutional Resident | |

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

Living Arrangements (Please check from the following):

Other: _____

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

Estimated *Monthly Household* Income: \$ _____

I Prefer Not to Respond

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

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

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

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)

- 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

Personal Support System:

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

Justice System:

- Federal Court
- Circuit Court
- Justice Court
- Jail
- Municipal Court
- Parole – including Juveniles
- Police or Sheriff

Tribal Affiliation (Please check from the following):

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

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