Kairos Counseling Services

www.kairoscounselingservices.com • Tel. 610.995.2800

Registration Inventory *(one per person)*

DATE OF INTAKE: / /

NAME *(Please circle one):* Mr. Mrs. Ms. Dr. Rev.	DATE OF BIRTH	SEX	AGE
STREET ADDRESS (Including house / Apt. #s)	CURRENT MEDICAL INSURANCE:		
(City) (State) (Zip)	SOCIAL SECURITY #:		
HOME PHONE / MOBILE / TEXT NUMBER	WORK PHONE		
ETHNICITY / HERITAGE / PRIMARY EMAIL ADDRESS			

MAY YOUR THERAPIST USE ANY OF THESE MODES OF COMMUNICATION TO REACH YOU? ☐ Yes ☐ No | **CHECK** IF OKAY | **CROSS OUT** IF UNSAFE / NOT OKAY

☐ Post-mail ☐ Email ☐ Voicemail ☐ Home Phone ☐ Mobile Phone ☐ Text Messaging ☐ Work Phone

DESIRED SERVICES: ☐ INDIVIDUAL ☐ GROUP ☐ PRE-MARITAL ☐ MARRIAGE ☐ FAMILY	HEARD ABOUT / REFERRED TO ME BY:

EMERGENCY CONTACT 1 (Name) (Phone & Address) (Relationship to you)

EMERGENCY CONTACT 2 (Name) (Phone & Address) (Relationship to you)

Relationship History

CURRENT STATUS

☐ SINGLE ☐ DATING ☐ COMMITTED RELATIONSHIP ☐ ENGAGED ☐ MARRIED ☐ LIVING TOGETHER ☐ RE-MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

YOUR SPOUSE or PARTNER's NAME	HIS / HER AGE	HIS / HER EDUCATION LEVEL AND/OR OCCUPATION	
HIS / HER RACE, ETHNIC HERITAGE	DATE MARRIED	DATE SEPARATED (If relevant)	DATE DIVORCED (If relevant)
IF YOU'VE BEEN SEPARATED FROM YOUR SPOUSE: 1. FROM _____ TO _____ 2. FROM _____ TO _____ 3. Other occasions: ☐ YES ☐ NO		HAVE YOU HAD OTHER: Marriages ☐ YES ☐ NO Separations ☐ YES ☐ NO Divorces ☐ YES ☐ NO	HAS YOUR SPOUSE HAD OTHER: Marriages ☐ YES ☐ NO Separations ☐ YES ☐ NO Divorces ☐ YES ☐ NO

CHILDREN	NAME	AGE	Relation: *stepson, adopted, etc.*	LIVING AT HOME ☐ YES ☐ No	MARITAL STATUS	OCCUPATION
	NAME	AGE	Relation: *stepson, adopted, etc.*	LIVING AT HOME ☐ YES ☐ No	MARITAL STATUS	OCCUPATION
	NAME	AGE	Relation: *stepson, adopted, etc.*	LIVING AT HOME ☐ YES ☐ No	MARITAL STATUS	OCCUPATION
	NAME	AGE	Relation: *stepson, adopted, etc.*	LIVING AT HOME ☐ YES ☐ No	MARITAL STATUS	OCCUPATION

YOUR PREVIOUS MARRIAGES (if any)

From _____To _____; Names of Children from this Marriage _____

YOUR SPOUSE / PARTNER'S PREVIOUS MARRIAGES (if any)

From _____To _____; Names of Children from this Marriage _____

Work History

CURRENT EMPLOYER NAME & LOCATION	POSITIONS HELD IN PAST	
CURRENT OCCUPATION & POSITION	EDUCATION, LEVEL COMPLETED, SUBJECT AREA	NET FAMILY INCOME BRACKET
ARE YOU SATISFIED WITH YOUR CURRENT WORK (OR EDUCATIONAL PROGRAM)? IF NOT, EXPLAIN:		

Religious Background

IS FAITH A RESOURCE FOR YOU? ☐ YES ☐ NO ☐ NOT SURE	FAITH OR DENOMINATIONAL PREFERENCE	VIEW OF GOD or HIGHER POWER
FAITH COMMUNITY	GEOGRAPHICAL LOCATION	ARE YOU A MEMBER? ☐ YES ☐ NO
LEADER YOU SEEK OVERSIGHT FROM — (NAME, ROLE)	WOULD YOU FIND IT HELPFUL FOR THERAPIST TO CONTACT THIS PERSON? ☐ YES ☐ NO ☐ OTHER:	

Medical Information

YOUR PHYSICIAN	PHYSICIAN LOCATION / CONTACT INFO.	DATE OF LAST MEDICAL EVALUATION
YOUR PSYCHIATRIST / PSYCHOLOGIST	PSYCH. LOCATION / CONTACT INFO.	PSYCHIATRIC DIAGNOSIS

SURGERIES / MEDICAL HOSPITALIZATIONS: ☐ YES ☐ NO

HAVE YOU HAD PSYCHIATRIC HOSPITALIZATIONS: ☐ YES ☐ NO

CHECK CONCERNS, OR DIAGNOSES YOU HAVE HAD. IF YOU THINK THEY ARE CONTRIBUTING TO CURRENT THERAPY NEEDS, ALSO **UNDERLINE**.

☐ Adoption ☐ Foster care	☐ Coordination	☐ Hunger (chronic)	☐ Panic ☐ Paranoia
☐ Abuse ☐ Violence ☐ Bullying	☐ Cutting/Self-injury:……..……....	☐ Heat/cold sensitivity	☐ Psychosis
☐ Alcohol ☐ Drug use	☐ Depression	☐ Heart issues	☐ PTSD, (Post-Traumatic Stress Dis.)
☐ Anger ☐ Anxiety	☐ Delusions	☐ Hypervigilance	☐ Recent weight changes
☐ Asperger's ☐ Autism	☐ Detachment ☐ Isolation	☐ Identity concerns	☐ Seizures
☐ Attention ☐ Hyperactivity	☐ Diabetes ☐ Hypoglycemia	☐ Incarceration; ☐ Delinquency	☐ Sexual Compulsivity or Addiction
☐ Brain / Head injury; Concussion	☐ Disability:……....	☐ Menstrual irregularities	☐ Sexual Concerns / Changes / Pain
☐ Bladder or Bowel problems	☐ Disorientation ☐ Dissociation	☐ Mental Illness……..……	☐ Skin Concerns
☐ Bipolar; ☐ Borderline Diagnosis	☐ Eating Disorder: ……	☐ Memory problems	☐ Social difficulties
☐ Body Image ☐ Self-image	☐ Fatigue; Weakness	☐ Multiple Sclerosis, Parkinson's, Etc.	☐ Speech problems ☐ Stroke
☐ Cancer: ……..……..	☐ Fertility issues; ☐ Impotence	☐ Nausea or vomiting	☐ Suicide ideation &/or ☐ Attempts
☐ Changes in Consciousness	☐ Fibromyalgia; ☐ Chronic pain	☐ Personality change: ……	☐ Thyroid concerns
☐ Codependency ☐ Enmeshment	☐ Hallucinations or Déjà vu	☐ Pneumonia	☐ Tremors ☐ Tourette's ☐ Turner's
☐ Conflict	☐ Headaches	☐ Pregnancy ☐Miscarriage ☐Abortion	☐ Visual distortions ☐Voices (hearing)

Current Medications	Purpose	Dosage	Started	Last used
……..……..	……	…….	….....	……...
……..……..	……	…….	….....	……...
……..……..	……	…….	….....	……...

Recreational Drugs	Amount	Frequency	Age Started	Last used
……..……..	……	…….	….....	……...
……..……..	……	…….	….....	……...
……..……..	……	…….	….....	……...

ADDITIONAL MEDS? ☐ YES ☐ NO

HRS SLEEP AVERAGED: Night:…….. Day:…… | RECENT CHANGES ☐Yes ☐No | RESTFUL ☐Yes ☐No

REGULAR MEALS? ☐ YES ☐ NO

UNDERLINE OR CIRCLE THE RESPONSE BELOW THAT BEST DESCRIBES YOUR SITUATION:

DO YOU SMOKE? ☐ YES ☐ NO
Frequency:……..……...

SUBSTANCE INTAKE:
☐ Coffee/ Tea, Stimulants:
Qty:……..
☐ Candy, Desserts, Soda:
Qty:……..
☐ Alcohol per day /wk:
Qty:……..……...

ENERGY:	Low all the time	Low some days	Average	More than usual	Very up & down
APPETITE:	Poor	Low some days	Average	Good	Has increased
SLEEP:	Poor	Difficult	Average	Good	Nightmares
MEMORY:	Poor	Difficult	Average	Good	
CONCENTRATION:	Poor	Difficult	Average	Good	
ANXIETY:	All the time	Most days	Some days	Not at all	
ANGER/IRRITATION:	All the time	Most days	Some days	Not at all	
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	

Legal Matters

Are you/ your child currently dealing with a legal issue? ☐No ☐Yes (Describe):

Have you/ your child been charged with a crime still pending in the legal system? ☐No ☐Yes (Charges):

Are you/ your child currently on probation or parole for a crime? ☐No ☐Yes (Charges):

Reason for Therapy:

WHEN PROBLEM BEGAN, (approximate date)	OTHER STRESS OR LOSS AT THAT TIME
RECENT PERSONALITY CHANGES, (withdrawal, intense moods, etc.)	RECENT CHANGES IN THINKING, MEMORY, WORK HABITS
WHEN & WHERE COUNSELING SOUGHT PREVIOUSLY	REASON FOR PRIOR COUNSELING (WAS IT HELPFUL): ☐Y ☐N ☐NOT SURE

I certify that the above information is accurate to the best of my knowledge. For parent, if client is a minor: I understand that confidentiality between my child and his/her therapist must be maintained except if a danger to self or others, or as required by law.

(PRINT) NAME OF CLIENT	SIGNATURE OF CLIENT	DATE
1 - (PRINT) NAME OF PARENT OR LEGAL GUARDIAN*	1 - SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE
2 - (PRINT) NAME OF PARENT OR LEGAL GUARDIAN*	2 - SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE

*Signature of parent or legal guardian is required if the counselee is a minor – *(under 18 in Pennsylvania).*