*Karis Counseling, LLC*
*Ashley Brewster, MA, LPC-I*
*Adolescents, Women, & Family Therapy*
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# CONFIDENTIAL

## CLIENT REGISTRATION

Date:_____________

Client's Name:____________________________________________________ Soc. Sec.____________
Home Address: ______________________________ City: __________________ State: ____ Zip: ______
Home Phone: ( ) _____________Cell:___________ Sex: _____ Age: _____ Date of Birth: ___/___/____
Patient Employer: _________________________________ Work Number: (____) _________________
Emergency Contact: ___________________________ Phone: (____) ____________________________
Primary Care Physician or Psychiatrist: _____________________________________________________
Last Medical Exam: ______________________________________________________________________
Medications: ____________________________________________________________________________
Have you seen a psychiatrist or counselor before?
Yes _______ No ________ When: _________________________________________________________
Presenting Problems:

| | | |
|---|---|---|
| __eating disorder | __sexual problems | __legal/financial issues |
| __excessive drinking | __appetite disturbance | __difficulty relaxing |
| __anger | __stomach problems | __fears / phobia |
| __drug abuse | __pain (where) | __obsessive thoughts |
| __nervousness | __low self esteem | __compulsive behaviors |
| __fatigue | __relationship problems | __ medical condition/disability |
| __panic attacks | __difficulty concentrating | __poor impulse control |
| __anxiety | __feelings of unreality | __confusion |
| __loneliness | __flashbacks | __difficulty trusting |
| __marital conflict | __depression | __cutting/self-injury |
| __intrusive thoughts | __bowel problems | __family conflict |
| __sleep disturbance/insomnia | __asthma | __sexual abuse |
| __headaches | __social isolation | __nightmares |
| __suicidal thoughts | __issues of loss | __dizziness/nausea |
| __homicidal thoughts | __parenting problem | __spiritual concerns |

Name of spouse:____________________ Age:____
Names/ages of children and step-children:_____________________________________________________
Others living in household:_________________________________________________________________
Goals you would like to see accomplished in therapy?____________________________________________
_______________________________________________________________________________________