

*Karis Counseling, LLC*  
*Kathy Pardue, MA, LPC, BCPC*  
*Adult, Couples, Adolescent, & Family Therapy*  
**(713) 501-0663**  
**kariscounseling@comcast.net**

CONFIDENTIAL

CLIENT REGISTRATION

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Soc. Sec. \_\_\_\_\_  
 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:

<input type="checkbox"/> eating disorder	<input type="checkbox"/> sexual problems	<input type="checkbox"/> legal/financial issues
<input type="checkbox"/> excessive drinking	<input type="checkbox"/> appetite disturbance	<input type="checkbox"/> difficulty relaxing
<input type="checkbox"/> anger	<input type="checkbox"/> stomach problems	<input type="checkbox"/> fears / phobia
<input type="checkbox"/> drug abuse	<input type="checkbox"/> pain (where)	<input type="checkbox"/> obsessive thoughts
<input type="checkbox"/> nervousness	<input type="checkbox"/> low self esteem	<input type="checkbox"/> compulsive behaviors
<input type="checkbox"/> fatigue	<input type="checkbox"/> relationship problems	<input type="checkbox"/> medical condition/disability
<input type="checkbox"/> panic attacks	<input type="checkbox"/> difficulty concentrating	<input type="checkbox"/> poor impulse control
<input type="checkbox"/> anxiety	<input type="checkbox"/> feelings of unreality	<input type="checkbox"/> confusion
<input type="checkbox"/> loneliness	<input type="checkbox"/> flashbacks	<input type="checkbox"/> difficulty trusting
<input type="checkbox"/> marital conflict	<input type="checkbox"/> depression	<input type="checkbox"/> cutting/self-injury
<input type="checkbox"/> intrusive thoughts	<input type="checkbox"/> bowel problems	<input type="checkbox"/> family conflict
<input type="checkbox"/> sleep disturbance/insomnia	<input type="checkbox"/> asthma	<input type="checkbox"/> sexual abuse
<input type="checkbox"/> headaches	<input type="checkbox"/> social isolation	<input type="checkbox"/> nightmares
<input type="checkbox"/> suicidal thoughts	<input type="checkbox"/> issues of loss	<input type="checkbox"/> dizziness/nausea
<input type="checkbox"/> homicidal thoughts	<input type="checkbox"/> parenting problem	<input type="checkbox"/> 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? \_\_\_\_\_  
 \_\_\_\_\_