

Today's	
Date:	

Legal Name (Last, First, M.I.):		DOB:	Age:	Birth Sex:	Gender:
Affirmed Name:		Pronouns:			
Preferred Language? Interpreter Needed? □ Yes □ No		SS#:			
Your Name/Relationship to individual seeking Services:			oregnant? olicable □ Ur		
Physical Street Address:		Mailing A	ddress: (If	different then	physical)
City: State:		Ci t y:		State:	
Zip:		Zip:			
Landline Phone:		Phone N	umber for R	eminder Calls	S!
☐ Detailed Message ☐ Detailed Tex	αt	Voice Re	minders:		
Youth Cell Phone:					
☐ Detailed Message ☐ Detailed Tex	αt	Text Rem	ninders:		
Guardian Cell Phone:					
☐ Detailed Message ☐ Detailed Tex	αt	Youth Em	ail:		
Checking the boxes above allows Kairos staff to voicemails and send detailed text messages.	to leave detailed				
Responsible Party(Parent or Legal	Guardian):	Responsi	ble Party(Pa	rent or Legal	Guardian):
Name:		Name:			
Street Address:		Street Ad	ldress:		
City: State:		City:		State	:
Zip:		Zip:			
Relationship:		Relations	ship:		
Phone #:		Phone #:			
Email:		Email:			
Emergency Contact: (outside of h	ousehold)	Highest	Grade Comp	oleted:	
Name:		Currently a Student			
Relationship:		School District:			
Phone #:		School Name:			
*Kairos has permission to ID incase of emergency	(<mark>Initial</mark>)				

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Health Insurance (Check all th	at apply): 🗆 I.D Verified [□ No I.D Available			
☐ AllCare: 740 SE 7 th Street, Grants F	ex (541)471-4128				
☐ Jackson Care Connect: 33 N Central Avenue, Medford, OR 97501 Phone (855)722-8208 Fax(503)416-3723					
☐ Medicaid Open Card or Other: Card	Number:				
☐ Medicare Card Number:					
	ID#:_				
	Subscriber Name:				
□ None					
*We currently only accept those covered	by Medicaid with AllCare or Jackson Care Conn	ect as their CCO. There is no copay			
for Medicaid members and you will not		V T			
Youth Race:	Youth Ethnicity:	Youth Tribal Status:			
☐ White	☐ Puerto Rican	☐ None/Not Applicable			
☐ Alaska Native	☐ Mexican	☐ Burns Paiute Tribe			
☐ American Indian	□ Cuban	☐ Confederated Tribes of Coos,			
☐ Black/African American	☐ Hispanic-Other origin	Lower Umpqua and Siuslaw			
☐ Asian	☐ Hispanic-No specific origin	☐ Confederate Tribes of Grand			
☐ Native Hawaiian/Pacific Islander	☐ Not Hispanic	Ronde			
☐ Other Single Race		☐ Confederated Tribes of Siletz			
☐ Two or more unspecified races	Youth Employment Status:	☐ Confederated Tribes of the			
	☐ Full Time (35 hours or more per	Umatilla			
Variable Maribal Chatasa	week)	☐ Confederated Tribes of Warm			
Youth Marital Status:	☐ Part Time (Less than 35 hours	Springs			
☐ Never Married	per week)	☐ Coquille Indian Tribe			
☐ Married	☐ Unemployed	☐ Cow Creek Band of Umpqua			
☐ Separated	☐ Homemaker	Indians			
□ Divorced	☐ Student	☐ Klamath Tribe			
☐ Widowed	□ Retired	□ Other			
Youth Living Arrangement:	☐ Disabled	Youth Legal Status:			
	☐ Unable to work due to being in	☐ 30 Day Civil Commitment			
☐ Other Private Residence	a hospital or institution	☐ 180 Day Civil Commitment			
☐ Private Residence at home	□ Volunteer	☐ Incarcerated			
alone or with immediate family ☐ Private Residence with relatives	☐ Sheltered/non-competitive	☐ Parole			
	☐ Not working and not looking for	☐ Probation			
non-parental adults or other relatives	work	☐ Psychiatric Security Review Board			
☐ Private Residence without	Youth Arrests:	(PSRB)			
relatives	Total Arrests in last 30 days:	☐ Juvenile Psychiatric Security			
☐ Foster Home	□ None	Review Board (JPSRB)			
☐ Transient/Homeless	Total Arrests in lifetime:	☐ Guardianship (Court)			
☐ Secure Residential Facility	□ None	☐ Guardianship (Child Welfare)			
☐ Residential Facility	Total DUII Arrests in last 30 days:	☐ Aid and Assist			
☐ Jail	□ None	□ None			
☐ Room and board	Total DUII Arrests in lifetime:	☐ Involuntary Custody			
☐ Supported Housing	□ None	☐ Pre-Arrest Jail Diversion			
☐ Supportive Housing Scattered	- None	☐ Post-Arrest Jail Diversion			
☐ Alcohol and Drug Free Housing		□ Unknown			
		- □ Voluntary			
Household Income Information		☐ Hold			
Annual Gross Household Income:\$		□ 14 Day Diversion□ Mental Health Court			
Number of People in Household: _		☐ DUII Diversion			
Number in each age group depend	ent on household	□ DUII Conviction			
income:		L DOII CONVICTION			
Individuals under 18:	Individuals under 18:				

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Household Source and Amount of Income: Wages/Salary \$ Retirement/Pension/Social Security Income:\$ Other (Alimony/Child Support, Care of foster child: \$ Unknown:\$ Public Assistance: \$ Disability/Social Security Disability:	Youth Veterans Status: Veteran with current or former active duty military Current or former guard/reserve with active duty Current or former guard/reserve with no active duty No Military service
\$ None(no source of income for household)	Religious Preference:
Referred By: Briefly describe what brought you here today:	
Youth Signature (14 and over)	
Parent/Guardian Signature	Date

Kairos Staff Only

Input Recieved By:

Date:



Jackson Services

10 Crater Lake Ave Medford, Oregon 97504 Office (541) 772-0127 Fax (541) 772-0966

Walk-in Hours

Tuesday and Wednesday – 12:00pm to 3:00pm

Thursday and Friday – 8:00am to 3:00pm

Crisis- Please call Jackson County

Mental Health at 541-774-8201

Emergency – 911



Admission Consent and Release Form Jackson Services

Youth's Name:	
D.O.B.:	Admission Date:
Youth's Preferred Language:	
	Consent to Treatment
	party(ies), hereby request services for the above named youth reatment as recommended and provided by the their Care Team.
Youth if 14 or over	Date
Parent or Guardian	Date Date
Kairos Representative	 Date
Agreement to Pa	articipate in Treatment and Aftercare
named youth while s/he is in the care of Kai	(ies) hereby agree to participate in the treatment of the above iros. Date
Parent or Guardian	
I have an Advanced Health Directive.	
	ective but would like information and assistance in creating one.
	ective and do not wish to establish one at this time. I understand I would like to create one, a Kairos representative will be made
I have a Declaration for Mental Health Ti	reatment.
It is located at:	
I do not have a Declaration for in creating one.	Mental Health Treatment but would like information and assistance

I do not have a Declaration for Mental Health Treatment and do not wish to establish one at this time. I understand that any time I determine that I would like to create one, a Kairos representative will be made available to help me do so.

Risks and Benefits of Treatment

Mental Health treatment can have many benefits, but also some risks. Kairos staff work diligently with youth and families to develop and utilize skills using the agency's treatment philosophy of Collaborative Problem Solving. Through the course of individual, group, family therapy, and/or skills training and peer support the discussion of unpleasant topics such as previous trauma may result in uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. However, treatment has been shown to have many benefits for those who go through it. Treatment often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Additionally, please know that we do not keep secrets. During the course of family therapy your Individual and Family Therapist may disclose information obtained during the course of individual work when working with other members of the family. Please ask to speak with your therapist or the program manager should you have any questions or concerns about the risks and benefits of treatment.

roditti 14 of over	Daic
Parent or Guardian	Date
Kairos Representative	 Date
Youth A	ge 14 and Over
or the involvement of your parent/guardian is belied to involve your parent/guardian prior to the end of your parent/guardian or primary caregiver at any po death to yourself, you plan to cause seriousharm or	rent or guardian. However, unless you are emancipated yed to be clinically harmful to you, attempts will be made treatment. Additionally, we may disclose information to oint if you disclose a plan to cause serious harm or death to someone else who can be identified, or you remotionally-or that you have been abused in the past
Youth	Date
Kairos Representative	 Date

We schedule appointments reserving that time just for you and/or your family. If you need to miss an appointment or will not be home during your scheduled appointment time, please provide Kairos with 24 hours' notice so that we may reschedule your time to benefit others.

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632- 9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377- 8642 (relay voice users). USDA is an equal opportunity provider and employer.

Vouth if 14 or over

KAIROS Health History—Jackson ServicesIn order to obtain a complete picture of you, we need some information about your health history and current health status. Please complete as much information as you know about the following.

Name of PCP: Clinic Name:				
Date of last visit: Phone Number:				
Dentist Name:	Clinic Name:	Clinic Name:		
Date of last visit:	Phone Number:_			
Date of last hearing exam:				
Date of last eye exam:				
Mental Health Provider:				
Date of last visit:	Phone Number:			
Do you have a history of self-harm or Please list the date(s) and describe:	or attempted suicide?			
Do you have a history of harming ot Please list the date(s) and describe:	her people or animals?			
Do you have any environmental aller Please list and note what type of rea	rgies?			
Are you allergic to any medications? Please list and note what type of rea				
Are you currently taking any medica	tions? no yes			
Name of Medication	Dosage and Instructions	Prescribing Provider		
Pharmacy Name:	Location:	<u> </u>		
Phone Number:				
Do you have any other health concerns	that you feel we should know about? Please	ovnlain:		
bo you have any other health concerns	that you leef we should know about: Flease	Слрішіті		

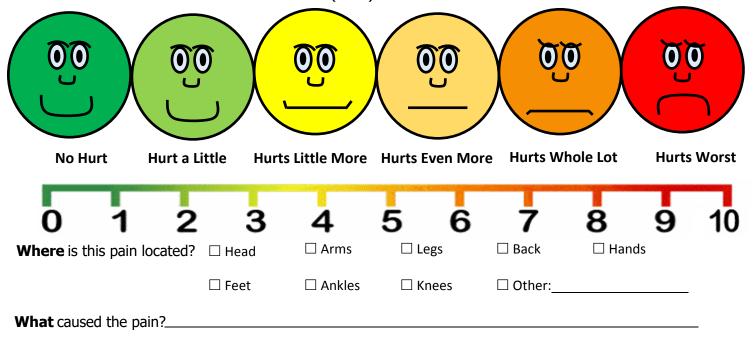
Please select any	of t	the following that you have experienced in the last 30 days: None
Eyes		Blurred Vision?
		Seeing Double?
		Seeing Halos?
	_	Eye Pain?
		Watering?
		Itching?
	_	Wear Glasses/Contacts?
Ears		Difficulty Hearing?
		Buzzing or Ringing?
		Frequent Earaches/Infections?
		Motion Sickness?
		Drainage?
		Use Hearing Aid(s)?
		Numbness/Tingling?
Nervous Systems		Trembling/Shaking?
		Fainiting Spells?
		Changes in Handwriting?
	0	
		Speech Difficulty?
		Loss of Muscle Strength? History of Seizures?
		-
		Date of last Seizure?
Digestive		Frequent Indegestion
Digodivo		Heartburn
		Frequent Bloating Bloated Stomach
		Loss of Appetite
		Nausea or Vomiting
		Spit up Blood
		Constipation
	ā	Diarrhea
		Black/Grey/Blood Stools
		Rectal Pain
		Rectal Bleeding
	-	Change in Stools
	_	Always Tired
General		Trouble Sleeping
		Often Crying
		Depressed
		Hopeless Outlook
		Considered Suicide
		Loss Temper Often
		Trouble Relaxing
		Anxiety
		Work/Family Problems
		Change in Memory/Concentration
		Sexual Difficulty/Problems
Head & Neck		Frequent Headaches?
		Migaines?
		Neck Pains?
		Lumps or Swelling?
041 0		Difficulty Swallowing?
Other?		

Youth	Name:
IVALII	11411161

Pain Screening:

What is your current physical pain level?

Please mark the one most accurate number (0-10) on the scale below.



Form completed by:

Vairos Poprosontai	tive Reviewing Form:			
Print Name	Sign Name	Relationship to Youth	<mark>Date</mark>	

Print Name Sign Name Title Date

Recommended follow-up with Primary Care Provider: Yes No



Youth and Family Information Attestation Jackson Services

Youth Name		DOB	
we the undersigned have been informed rovided by Kairos. Please initial in the lin		information regarding services	
After-Hours Crisis Suppo	rt Information		
Notice of Privacy Practice	es		
Abuse Reporting Guidelin	e		
Custody Disclosure			
Client and Family Rights			
Voter Registration Inform	nation		
Grievance Procedure "Ha	ve A Problem Or A Complair	nt?"	
Behavior Support Philoso	phy		
Feedback Informed Trea	tment (FIT) and OpenFIT U	Jse Disclaimer	
Home Safety Service Deli	ivery Agreement		
Video Surveillance Ackno	wledgement		
Attendance Policy			
Youth if 14 or over (Print Name)	Signature	Date	
Parent and/or Legal Guardian (Print Name)	Signature	Date	
KAIROS Representative (Print Name)	Signature	Date	
Youth refused to sign for the receipt of the were given to the youth and/or parent/le	-	ver copies of all the above guide (Kairos Representative)	