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Intake Form

Date \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Sex (M/F) DOB \_\_\_\_\_ Do I have permission to mail to this address? Y / N

Email Address \_\_\_\_\_ Do I have permission to email you? Y / N

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is it acceptable to contact you at home? Y / N If "no" then how can I contact you?  
\_\_\_\_\_

Are you currently under medical care? Y / N If yes, please explain/describe.  
\_\_\_\_\_

Name of Primary Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently taking prescribed medications? Y / N If yes, please briefly explain/describe.  
\_\_\_\_\_

Have you been under the care of a psychiatrist, psychologist, or counselor? Y / N

If yes, please give the name, date, and location of the therapy and briefly explain the problem.  
\_\_\_\_\_

How were you referred to my office? \_\_\_\_\_

May I thank the referral source? Y / N

Emergency Contact/Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

*Please circle any of the following struggles that pertain to you:*

Anger Anxiety Depression Cutting/Self Harm Past Suicide Attempt Suicidal Thoughts

Health Issues Fears/Phobias Finances Eating Disorder Work/Stress Insomnia Relationships

Client Signature \_\_\_\_\_ Date \_\_\_\_\_