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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 _____