Jamelyn Keatts, MA LMHC
Jamelyn@jamelynkeatts.com // 408.836.2896

2900 Eastlake Ave E., Suite 220
Seattle, WA 98102

Date ____________ Last Name _________________________ First Name __________________________

Address ____

City _______________________________________ State _____________ Zip ____________________

Email Address____

Home Phone ___________________________ Work/Cell Phone ________________________________

Sex (M/F) _____________________ DOB ________________

Emergency Contact (name/phone): ____

Is it acceptable to contact you at home or cell? Home: Y / N Cell: Y / N

If "no" to both, then how can I contact you? ____

Is it acceptable for me to leave a voice message on preferred method of contact? Y / N

Are you currently under medical care? Y/N

If yes, then please explain/describe. ____

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____

Name of personal Physician & Phone Number: ____

Are you currently taking prescribed medications? Y / N

If yes, then please explain/describe. ____

____

List any psychiatric/mental health medications you have taken. _____________________________________

____

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 explain the nature of the problem which

required attention ____

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

Anxiety	Depression	Fears/Phobias	Sexual Problems	Suicidal Thoughts
Separation/Divorce	Finances	Drug/Alcohol Use	Career Choices	Self--Control
Unhappiness	Insomnia	Work/Stress	Health Problems	Cutting/Self--Mutilation
Eating Disorders	Relationships	Anger	Religious Matters	Thought Patterns

How did you hear about me? ____

May I add you to my mailing list for future communications regarding client care & practice updates? Y / N