KATHERINE YOST, PhD, LMFT
Washington State Licensed Marriage and Family Therapist #LF 60034433
325 – 118th Ave SE Suite 210
Bellevue, WA 98005
425.405.0494 katherine@yostphd.com

CLIENT INFORMATION

Name (s)_____ Date_____

Names/relationship of others who will be in therapy with you: _____

_____

Address_____

City_____ ZIP_____

Email _____ OK to leave a message? _____

Preferred phone number _____ OK to leave a message? _____

Emergency contact_____ Emergency phone_____

Birth date _____

How were you referred to me? _____

Reason for seeking psychotherapy *now*_____

_____

All previous psychotherapy experiences _____

_____

Primary care physician _____ Office phone _____

Psychiatrist/ARNP _____

Are you taking any psychotropic medications? Please list each medication and the prescriber.

_____

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