Stacy Ingraham LLC

Client Information

_____	_____	_____	_____
Today's Date	*Name (first, middle, last)*	*Date of Birth*	*Age*

_____

Address *City* *State* *Zip*

_____

Emergency Contact: Name *Phone* *Relationship*

Background Information and History of Client

In your own words, describe what brings you here: _____

_____

_____

What do you hope to take away from this experience?_____

_____

What concerns/symptoms contributed to you coming in today? _____

_____

What has been helpful to you in dealing with these concerns/symptoms? _____

_____

Have you ever had treatment by, or are you currently seeing a psychiatrist or therapist? _____Yes _____No

Medical Information

Chronic health problems or disabilities we should be aware of? _____

Recent medical problems? _____

Current medications:_____

Substance Use

Do you feel you are addicted to anything (i.e. work, sex, alcohol, drugs, exercise, food)? ___Yes ___No

If yes, please describe: _____

Have you ever felt the need to cut down on your drinking and/or drug use? ____Yes ____No

Has anyone ever expressed concern about your alcohol and/or drug use? ____Yes ____No

If so, have you found those questions annoying or intrusive? ____Yes ____No

Do you use alcohol and/or drugs to *(check all that apply):* ___Manage stress ___Relax ___Change mood ___Sleep

Family/Relationship/Household Information

Have any members of your family had problems with:___Drugs ___Alcohol ___Depression ___Anxiety ___Other

Are you: ___ Dating ___Divorced ___Married ___Partnered ___Single ___Widowed ___Other

If applicable, please describe your current relationship by placing an "X" on the line below:

_____

No problems ***Minor concerns*** ***Moderate concerns*** ***Serious concerns***

How long have you been in the relationship? _____

If you are involved with parenting any children, please list the following:

Name	**Age**	**Name**	**Age**
_____		_____	
_____		_____	
_____		_____	

How would you describe your relationship with the children? _____

_____

How did you learn about Stacy Ingraham, MSEd., LPCC-S?

___Social Media ___Friend ___Medical Provider ___Internet Search ___Workshop ___Employer ___Therapist

___School Professional (teacher, school counselor) ___Other _____

Communication Preferences

Please call, email and/or text me at the following numbers regarding appointments, payments/billing, and cancellations:

Cell Phone _____ May Stacy Ingraham leave a message? ___Yes ___No

May Stacy Ingraham send text messages? ___Yes ___No

Email _____

Please list anyone who will call us to schedule/cancel/confirm appointments, make payments on your account, bring clients to their appointment, etc. (be sure to list your spouse, children, parents, assistants, babysitters/nanny, etc.)

Name_____ Relationship to you_____

Phone Number _____

Name _____ Relationship to you _____

Phone Number _____

Name _____ Relationship to you _____

Phone Number _____

Client/Legal Guardian Printed Name_____

Client/Legal Guardian Signature_____ **Date**_____