We are grateful that you have chosen Footprints to walk with you on your wellness journey. We look forward to putting the experience of our counselors to work for you. Please fill out the following information to the best of your ability before your first appointment.

Patient Information

Full Name:____

Date of Birth:__________________________ Today's Date:__________________________

Address:____

Phone Number:_______________________ Email:_______________________________

Marital Status:_________________________

Current Concerns

What concerns do you have that led you to come into counseling?

____

____

How long have you had these concerns?____________________________________

Employment Information

What is your employment status?____________________________________

What is your highest level of education?_________________________________

Family Information

Name	Age	Relationship

Explain your living situation.____

____

Trauma History

Have you ever experienced trauma, abuse, or neglect in the past? ☐ Yes ☐ No

If Yes, please explain:____

____

Do you have a history of domestic violence? ☐ Yes ☐ No

If Yes, please explain:____

Have you ever attempted suicide? ☐ Yes ☐ No

If Yes, please explain:____

Have you ever had any legal/court issues, including CPS and Friend of the Court? ☐ Yes ☐ No

If Yes, please explain:____

Mental Health History

Is there a history of mental health issues in your family? ☐ Yes ☐ No

If Yes, please explain:____

Has anyone attempted suicide in your family? ☐ Yes ☐ No

If Yes, please explain:____

Mental Health and Medical Treatment

Have you been in counseling before? ☐ Yes ☐ No

Who did you see and for what reason?____

____

What was helpful about that counseling?

____

Do you see a psychiatrist? ☐ Yes ☐ No

If Yes, who do you see:____

Are you currently on any medications? ☐ Yes ☐ No

If Yes, please list your medications:____

Do you have any medical issues? ☐ Yes ☐ No

If Yes, please explain:____

Please describe your eating habits:____

____

Please describe your sleeping habits:____

____

Substance Abuse

Do you abuse any substances (alcohol, tobacco, prescription or street drugs)? ☐ Yes ☐ No

If Yes, please explain (what, how often, and how much):________________________________

____

Are people close to you concerned about your substance use? ☐ Yes ☐ No

If Yes, please explain:____

Is there a history of substance abuse in your family? ☐ Yes ☐ No

If Yes, please explain:____

Is there any other information about you that would be helpful to know?

____

____

Patient Signature:_______________________________________ Date:________________

Counselor Signature:____________________________________ Date:________________