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

Childs' Full Name:____

Date of Birth:__________________________ Today's Date:_________________________

Address:____

Phone Number:_______________________ Email:______________________________

Current Concerns

What concerns do you have about this child that led you to bring them into counseling?

____

____

How long have you had these concerns?____

Strengths and Support

What are this child's strengths?____

____

What does this child enjoy doing?____

____

Who is supportive in this child's life?____

____

Family Information

Name	Age	Relationship

Are the parents divorced/separated? ☐ Yes ☐ No

If Yes, what are the custody arrangements?____

Is this child adopted? ☐ Yes ☐ No

School Information

What school does this child attend?____

What grade are they in?____

What are their grades typically like?____

Are there any concerns at school (academically, socially, or behaviorally)? ☐ Yes ☐ No

If yes, please explain:____

____

Health and Developmental History

Were there complications during pregnancy or birth? ☐ Yes ☐ No

If yes, please explain:____

Are there concerns about this child's development now or in the past? ☐ Yes ☐ No

If yes, please explain:____

____

Does this child have any health problems now or in the past? ☐ Yes ☐ No

If yes, please explain:____

____

Is this child on any medications or supplements? ☐ Yes ☐ No

If yes, please explain:____

What are this child's eating habits like?____

____

What are this child's sleeping habits like?____

____

Trauma History

Has this child experienced trauma, abuse, or neglect in the past? ☐ Yes ☐ No

If Yes, please explain:____

____

Is there a history of domestic violence in the home? ☐ Yes ☐ No

If Yes, please explain:____

Has this child ever attempted suicide? ☐ Yes ☐ No

If Yes, please explain:____

Has this child 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 this child's family? ☐ Yes ☐ No

If Yes, please explain:____

Has anyone attempted suicide in this child's family? ☐ Yes ☐ No

If Yes, please explain:____

Mental Health Treatment

Has this child been in counseling before? ☐ Yes ☐ No

Who did this child see and for what reason?____

____

What was helpful about that counseling?

____

Does this child see a psychiatrist? ☐ Yes ☐ No

If Yes, who do you see:____

What medications is the psychiatrist prescribing?______________________________________

Substance Abuse

Does this child use any substances (alcohol, tobacco, prescription/street drugs)? ☐ Yes ☐ No

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

____

Is there a history of substance abuse in this child's family? ☐ Yes ☐ No

If Yes, please explain:____

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

____

____

Completed By:_____________________________________ Date:___________

Counselor Signature:________________________________ Date:___________