**Check program(s) of interest:** Healthy Families Foothills Counseling and Supportive Services

**Client information**

**Name:** Click to enter text. **Client DOB:** Click to enter text. **Phone:** Click to enter text.

**May we text?** Choose an item. **May we leave a message?** Choose an item.

**Mailing address**: Click here to enter text. **City:** Enter text. **State:** Enter text.  **Zip:** Enter text.

**Alternate phone number**: Click here to enter text. **Owner of phone number:** Click here to enter text.

**Do you have transportation?** Choose an item. **Is DSS currently involved?** Choose an item.

**Currently pregnant?** Choose an item. **If yes, due date?** Click to enter text. **First time mom?** Choose an item.

**Healthy Families Referral (only)**

**I am currently single (includes divorced, separated, widowed or never married).** Choose an item.

**I am not currently working or employed.** Choose an item.

**My husband/partner/father of the baby is not working or employed.** Choose an item.

**I have no income or not enough income to cover my bills and other needs.** Choose an item.

**My housing is temporary, stressful, or overcrowded.** Choose an item.

**I do not have a phone.** Choose an item.

**I have not yet completed high school or a GED (includes still in school).** Choose an item.

**My emergency contact is:** Click here to enter text. **Phone number:** Click here to enter text.

**I have used drugs or alcohol more than once.** Choose an item.

**I began receiving prenatal care between:** 1 – 12 weeks  13 weeks or later

**I have had** Click here to enter text. **abortions in the past.**

**I have had treatment for mental illness.** Choose an item.

**I have thought about aborting this pregnancy.** Choose an item.

**I have thought about adoption for this pregnancy.** Choose an item.

**I am currently having problems with my family or my partner.** Choose an item.

**I am currently being treated for depression.** Choose an item.

**Counseling Referral (only)**

**Employment status:** Choose an item. **Is current housing stable?** Yes

**Check the area(s) of trauma that apply:** Sexual  Verbal/Emotional  Physical  Other: Click to enter.

**Do you have any mental health diagnoses?** No **If yes, please list:** Click here to enter text.

**Main reason for seeking services:** Click here to enter text. **Number of children:** Click here to enter text.

**Any behavior/discipline problems with child/children?** Click here to enter text.

|  |  |  |
| --- | --- | --- |
| **Child’s Name** | **Child’s DOB** | **Where is child currently living?** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Referring Agency:**  Click here to enter text. **Contact Name**: Click here to enter text.

**Phone Number:** Click here to enter text. **Date:** Click here to enter text.

ELECTRONIC SIGNATURE. This Acknowledgement and Certification of Understanding ("Acknowledgement") is to let you know that by submitting an electronic signature, you are providing an electronic mark, which is held to the same standard as a legally binding equivalent of a handwritten signature provided by you. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

**Client Name:** Click here to enter text.

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Sign if using paper copy)