Rcvd Date: ____________________ Client No: _____________________

Center for Psychological Services and Development

Monroe Park Campus ° 612 North Lombardy Street ° P.O. Box 843033 ° Richmond, VA 23284-3033
Phone: 804 828-8069 ° Fax: 804 827-1269 ° TDD: 1-800-828-1120
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APPLICATION FOR ADULT SERVICES

Name: (please print) ____ Date:________________
Last, First

Address: ____
Street / PO Box, City State ZIP

Mailing address: (if different) ____
Street / PO Box, City State ZIP

Telephone No(s): **(circle preferred)** (H):_________________ (W): _________________ (C): _________________

How did you hear about us? ____

Services you are seeking:

Therapy: ☐ Individual ☐ Couples ☐ Family ☐ Group ☐ Anxiety Clinic ☐ Behavior Medicine (i.e., pain, chronic illness)

Assessment: ☐ Career ☐ Academic ☐ Personality ☐ Other ______________________________

Military Service (If no military service, skip to next section): Are you a Combat Veteran? ☐ Yes ☐ No

Service History: ☐ Current Active Duty ☐ Current Reserves/National Guard
☐ Former Active Duty ☐ Former Reserves/National Guard

Branch of Service: ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard

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Insurance status: ☐ Private ☐ VCC/MCV code ☐ Medicare/Medicaid ☐None

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Personal information: Are you a student? ☐ Yes ☐ No

DOB: _________________ Age: _______ Gender: _________________________

Sexual orientation: ____________________________ Ethnicity: __________________________

Occupation: __________________________________ Total family income (before taxes): ___________/yr

For Office Use Only

Therapist Name: ____________________________ **Supervisor Name:** ________________________________

Assigned Date: __________________ **Treatment Fee: $**__________ **Assessment Fee: $**__________

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Work status: (check one) ☐ Unemployed ☐ Employed Full-time ☐ Employed Part-time
☐ Disabled ☐ Other _______________________________________

Relationship status: (single, married, divorced, etc) ____

With whom do you live? ____

____

____

Medical information:

Have you had any serious or chronic medical or physical problems? ☐ No

☐ Yes, (what? when?), ____

____

Are you currently on any medication for this problem(s)? ☐ No

☐ Yes, (names / dosages), ____

____

____

Primary care medical provider:

Name: _____________________________________ Telephone No.:___________________________

History:

1. What are some of the feelings/thoughts you are experiencing? (check all that apply)
   - ☐ anger ☐ depression ☐ anxiety/panic ☐ alcohol/drugs ☐ fears
   - ☐ crying all the time ☐ acting out in school ☐ learning problems ☐ confusion
   - ☐ relationship issues ☐ life adjustment/enhancement ☐ other_______________________
2. In your own words, please describe briefly the problem that you are experiencing.

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3. How long have you been feeling this way? _________________________________
4. Has anything happened recently or changed in your life that might be related to these feelings?
   (check all that apply) ☐ recent loss or death of close friend/family member ☐ change or loss in work or living situation ☐ other ____
5. Have you felt this way in the past? ☐ No
   ☐ Yes, (please describe) ____
   ____
   ____
6. Have you experienced any recent changes in the amount of time you sleep?
   ☐ No change ☐ Sleep more ☐ Sleep less
7. Have you experienced any recent changes in the amount of food you eat?
   ☐ No change ☐ Eat more ☐ Eat less
8. Have you ever been in a drug or alcohol treatment program? ☐ No
   ☐ Yes, (for what? when?) ____
   ____
9. Have you ever been hospitalized for psychological reasons (e.g., for depression)? ☐ No
   ☐ Yes, (for what? when?) ____
   ____
   ____
10. Are you currently taking any medications for anxiety, depression, ADHD, etc.? ☐ No
    ☐ Yes, (names/dosages) ____
    ____
    ____
11. Have you ever been charged or convicted of a crime (misdemeanor or felony)? ☐ No
    ☐ Yes, (please explain) ____
    ____
12. How many alcoholic drinks do you have in a typical week? (check one)
    ☐ None ☐ 0-3 ☐ 4-7 ☐ 8-11 ☐ 12-15 ☐ more than 15
13. Do you use any street drugs or medications prescribed for someone else?
    ☐ Yes ☐ No
14. Are you ever involved in physical fights with other people?
    ☐ Yes ☐ No
15. Are you currently, or have you ever, been involved in the legal system?
    ☐ Yes ☐ No
16. Has your family ever been involved with Child Protective Service?
    ☐ Yes ☐ No
17. If you have children, have you ever lost custody of your children?
    ☐ Yes ☐ No ☐ Do not have children

Thank you for taking the time to fill out our application. An Intake Coordinator will be in touch with you soon to continue the processing of your application.