

Rcvd Date: \_\_\_\_\_

Client No: \_\_\_\_\_



### Center for Psychological Services and Development

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## APPLICATION FOR CHILD SERVICES

Child's Name: (please print) \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First

Address: \_\_\_\_\_  
Street / PO Box, City State Zip

Ethnicity: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Child's Legal Custodian(s): \_\_\_\_\_

### Services You Are Seeking:

- Therapy:  Individual  Couples  Family  Child Issues  Group
- Anxiety Clinic  Behavior Medicine (i.e., pain, chronic illness)  Autism Clinic
- Assessment:  Career  Academic  Personality  Other \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Insurance Status:  Private  VCC/MCV code  Medicare/Medicaid  None

### School Information:

Name of child's school: \_\_\_\_\_

Address of school: \_\_\_\_\_

Child's current grade placement: \_\_\_\_\_ Teacher: \_\_\_\_\_

### Primary Caretaker / Guardian Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street / PO Box, City State Zip

Telephone No(s): (circle preferred) (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Relationship Status: (Single, Married, Divorced, etc) \_\_\_\_\_

Work Status: (check one)  Student  Employed Full-time  Employed Part-time  
 Unemployed  Disabled  Other \_\_\_\_\_

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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**Secondary Caretaker / Guardian Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street / PO Box, City State Zip

Telephone No(s): (circle preferred) (H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

**Medical Information (Child):**

Has your child experienced any of the following medical problems?

- Medical Hospitalization       Psychological Hospitalization       Surgery       Chronic illness
- Asthma       Head injury       High fever       Convulsions/seizures       Eye/ear problems
- Serious accident       Serious illness       Hearing problems       Allergies
- Loss of consciousness       Other: \_\_\_\_\_

Please describe any serious or chronic medical or physical problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list current and past medications below. Please include (a) name of medication, (b) dates taken, (c) dosage (ex – 10mg twice daily) (d) name of prescribing doctor: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Primary Care Medical Provider:

Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

**History (Child)**

1. What are some of the feelings/thoughts your child is 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 your child is experiencing.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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3. How long has he/she been feeling this way? \_\_\_\_\_
4. Has anything happened recently or changed in his/her 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. Has he/she felt this way in the past?  No  
 Yes, (please describe), \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Has your child experienced any of the following problems at school?  
 fighting  lack of friends  drug/alcohol  detention  suspension  
 learning disabilities  poor grades  gang influence  incomplete homework  
 behavior problems  poor attendance  other: \_\_\_\_\_
7. Behavioral Excesses - What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Behavioral Deficits - What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Treatment Goals – Which of your child’s problem behaviors do you want to see addressed?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Has your child had counseling before?  Yes  No
11. Has your child ever experienced any type of abuse (physical, sexual, or verbal)?  No  
 Yes, (please describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
12. Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? Has he/she ever purposely hurt himself or another?  No  
 Yes, (please describe) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
13. Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)?  No  
 Yes, (please explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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14. Has he/she ever been charged or convicted of a crime (misdemeanor or felony)?  No  
 Yes, (please explain) \_\_\_\_\_

15. Do you have any other concerns about your child or your family that you have not mentioned yet?  No  
 Yes, (please explain) \_\_\_\_\_

**History (Primary Caretaker/Guardian):**

1. Have you ever been hospitalized for psychological reasons (e.g., for depression)?  No  
 Yes, (for what? when) \_\_\_\_\_

2. Are you currently taking any medications for anxiety, depression, ADHD, etc.?  No  
 Yes, (names/dosages) \_\_\_\_\_

3. 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

4. Do you use any street drugs or medications prescribed for someone else?  
 Yes     No

5. Are you ever involved in physical fights with other people?  
 Yes     No

6. Are you currently, or have you ever, been involved in the legal system?  
 Yes     No

7. Has your family ever been involved with Child Protective Service?  
 Yes     No

8. Have you ever lost custody of your children?  
 Yes     No

**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.**