VIRGINIA COMMONWEALTH UNIVERSITY

Center for Psychological Services and Development (CPSD)
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APPLICATION FOR CHILD SERVICES

Date: ____________________

Please complete all sections labeled Child with your child's information and Guardian with your information.

Child

Name: (please print) ____ DOB: __________ Age: _____
Last, First

Enrolled in school? ☐ Yes (district:____) ☐ No

Highest Education Level Completed: ☐ None yet ☐ Grade school ☐ High school ☐ Other__________________________

Race / Ethnicity: ☐ Asian ☐ American Indian/Native Alaskan ☐ Black/African American ☐ Hispanic/Latino
☐ Multi-racial ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other____________________________________

Sex: ☐ Female ☐ Male ☐ Intersex ☐ Other______________________

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer/Non-binary ☐ Transgendered ☐ Other___________________

Preferred Gender Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Ze/Zir ☐ Other__________________________

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Queer ☐ Don't know
☐ Other____

Household Makeup (child's living situation): ☐ Family (parents and children) ☐ Extended family ☐ Single-parent family
☐ Other____

Guardian A (required)

Relationship to child? ☐ Parent ☐ Legal guardian ☐ Legal representative ☐ Other ________________________

Responsible for medical decisions for child? ☐ Yes ☐ No

Name: (please print) ____ DOB: __________ Age: _____
Last, First

Address: ____
Street / PO Box, City State Zip

Telephone #: ______________________________ Alternate telephone #: ____________________________

Race / Ethnicity: ☐ Asian ☐ American Indian/Native Alaskan ☐ Black/African American ☐ Hispanic/Latino
☐ Multi-racial ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other____________________________________

Sex: ☐ Female ☐ Male ☐ Intersex ☐ Other______________________

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer/Non-binary ☐ Transgendered ☐ Other____________________

Preferred Gender Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Ze/Zir ☐ Other_________________________

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Queer ☐ Don't know
☐ Other____

Highest Education Level Completed: ☐ None ☐ Grade school ☐ High school ☐ Trade/Technical school ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Medical/Doctorate degree ☐ Other__________________________

Employment Status: ☐ Student ☐ Employed full-time (occupation: ____________________________________)
☐ Employed part-time ☐ Not employed ☐ Disabled ☐ Retired ☐ Other____________________________________

Relationship Status: ☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Separated ☐ Widowed ☐ Other_____________

Military Service? ☐ Yes ☐ No Combat Veteran? ☐ Yes ☐ No

Are you involved with the legal system? ☐ No

☐ Yes (describe), ____

____

Are you involved with Child Protective Services? ☐ No

☐ Yes (describe), ____

____

Have you ever lost custody of your children? ☐ No

☐ Yes (describe), ____

____

Guardian B (optional)

Relationship to child? ☐ Parent ☐ Legal guardian ☐ Legal representative ☐ Other _________________________

Responsible for medical decisions for child? ☐ Yes ☐ No

Name: (please print) ____ DOB: ___________ Age: ______
Last, First

Address: ____
Street / PO Box, City State Zip

Telephone #: ______________________________ Alternate telephone #: ____________________________

Race / Ethnicity: ☐ Asian ☐ American Indian/Native Alaskan ☐ Black/African American ☐ Hispanic/Latino
☐ Multi-racial ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other_____________________________________

Sex: ☐ Female ☐ Male ☐ Intersex ☐ Other______________________

Gender Identity: ☐ Female ☐ Male ☐ Genderqueer/Non-binary ☐ Transgendered ☐ Other____________________

Preferred Gender Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Ze/Zir ☐ Other_________________________

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Queer ☐ Don't know
☐ Other____

Highest Education Level Completed: ☐ None ☐ Grade school ☐ High school ☐ Trade/Technical school ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Medical/Doctorate degree ☐ Other__________________________

Employment Status: ☐ Student ☐ Employed full-time (occupation: ____________________________________)
☐ Employed part-time ☐ Not employed ☐ Disabled ☐ Retired ☐ Other____________________________________

Relationship Status: ☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Separated ☐ Widowed ☐ Other_____________

Military Service? ☐ Yes ☐ No Combat Veteran? ☐ Yes ☐ No

Are you involved with the legal system? ☐ No

☐ Yes (describe) ____

____

Are you involved with Child Protective Services? ☐ No

☐ Yes (describe) ____

____

Have you ever lost custody of your children? ☐ No

☐ Yes (describe) ____

____

Parents / Guardians (A&B) Relationship: ☐ Never married ☐ Married ☐ Partnered ☐ Separated
☐ Divorced (☐ (A) remarried ☐ (B) remarried) ☐ Other ____

Services Requested | Child

Services you are you seeking:

- ☐ Individual Therapy (regular, weekly meetings with a therapist)
- ☐ Group Therapy (regular, weekly meetings with other clients and therapists)
- ☐ Therapy (individual and/or group therapy)
- ☐ Evaluation (testing with a feedback report)
- ☐ Evaluation and Therapy

Are you seeking services with a specialty clinic? ☐ Yes (☐ ADHD Clinic ☐ Anxiety Clinic) ☐ No

Were you referred? ☐ Yes ☐ No

If yes, from where? (agency or provider's name) ____

If no, how did you find us? ____

Are services mandated by a court? ☐ Yes ☐ No *CPSD does not provide custody evaluations*

Do you need to receive services by a certain date? ☐ Yes (date: ______________________) ☐ No

Name of person/agency responsible for paying fees (responsible party): ____________________________________

Responsible party's telephone #: ____________________________

Responsible party's relationship to child? ☐ Parent ☐ Legal guardian ☐ Legal representative ☐ Services agency
☐ Services provider ☐ Other ____

Total Annual Income: ☐ agency or other provider is responsible for fees ☐ 0 to 10,000
☐ 10,001–20,000 ☐ 20,001–30,000 ☐ 30,001–40,000 ☐ 40,001–50,000
☐ 50,001–60,000 ☐ 60,001–70,000 ☐ 70,001–85,000 ☐ 85,001 or more

Include income of all adult members in responsible party's immediate household plus any additional income from child support or other sources.

Total Number of Family Members/Dependents: _______________

Count the number of non-working family members in responsible party's immediate household.

Insurance Status: ☐ Private ☐ VCC/MCV ☐ Medicaid ☐ Medicare ☐ None *CPSD is not part of any ins. plan and does not file claims*

History | Child

Child's emotional health? ☐ Good ☐ Fair ☐ Poor

Has your child received counseling or psychotherapy in the past? ☐ No

☐ Yes (when? how long?) ____

____

Has your child been evaluated by a psychologist in the past? ☐ No

☐ Yes (when?) ____

____

Has your child been hospitalized for emotional or psychiatric reasons? ☐ No

☐ Yes (what? when?) ____

____

What is your child currently experiencing? (check all that apply)

☐ aggression	☐ anger	☐ anxiety / panic	☐ confusion
☐ crying	☐ depression	☐ fears	☐ withdrawal
☐ sleeping problems	☐ eating problems	☐ relationship problems	☐ substance abuse problems
☐ social problems	☐ life adjustment problems		

If any checked, for how long: ____

Has your child experienced any of the following at school? (check all that apply)

☐ fighting	☐ lack of friends	☐ detention / suspension	☐ gang influence
☐ behavior problems	☐ poor attendance	☐ poor performance	☐ learning disabilities

If any checked, for how long: ____

Describe the problems your child is currently experiencing.

____

____

____

____

____

Has your child purposely hurt himself/herself? ☐ No

☐ Yes (please describe) ____

____

Has your child purposely hurt another person? ☐ No

☐ Yes (please describe) ____

____

Has your child experienced physical abuse? ☐ Yes ☐ No ☐ Unsure

Has your child experienced sexual abuse? ☐ Yes ☐ No ☐ Unsure

Has your child experienced emotional or verbal abuse? ☐ Yes ☐ No ☐ Unsure

Child's physical health? ☐ Good ☐ Fair ☐ Poor

Does your child have any serious or chronic medical or physical problems? ☐ No

☐ Yes (what?) ____

____

Is your child currently taking any medication? ☐ No

☐ Yes (names? dosages?) ____

____

Primary-care doctor's name: _____________________________________ Telephone #:__________________

What more do we need to know about your child?

____

____

____