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

Date: ___________________

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____

Student Status: ☐ Full-time student (school: _________________________________) ☐ Part-time student ☐ Not a student

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______________

Household Makeup: ☐ Alone ☐ Roommates ☐ Spouse/Partner/Committed other ☐ Family (parents and children) ☐ Extended family ☐ Single-parent family ☐ Other____

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

Services Requested

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 (☐ 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 applicant? ☐ Self ☐ 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

Your emotional health? ☐ Good ☐ Fair ☐ Poor

Have you received counseling or psychotherapy in the past? ☐ No

☐ Yes (when? how long?) ____

____

Have you been evaluated by a psychologist in the past? ☐ No

☐ Yes (when?) ____

____

Have you been hospitalized for emotional or psychiatric reasons? ☐ No

☐ Yes (what? when?) ____

____

What are you 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: ____

Have you experienced any of the following at school/work? (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 your current problems and concerns.

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Have you purposely hurt yourself? ☐ No

☐ Yes (please describe) ____

____

Have you purposely hurt another person? ☐ No

☐ Yes (please describe) ____

____

Have you experienced physical abuse? ☐ Yes ☐ No ☐ Unsure

Have you experienced sexual abuse? ☐ Yes ☐ No ☐ Unsure

Have you experienced emotional or verbal abuse? ☐ Yes ☐ No ☐ Unsure

Your physical health? ☐ Good ☐ Fair ☐ Poor

Do you have any serious or chronic medical or physical problems? ☐ No

☐ Yes (what?) ____

____

Are you currently taking any medication? ☐ No

☐ Yes (names? dosages?) ____

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

What more do we need to know?

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