



VCU

Center for Psychological Services and Development

Department of Psychology | College of Humanities and Sciences
612 N Lombardy St | Box 843033 | Richmond, VA 23284-3033
804 828-8069 | fax: 804 827-1269 | cpsd@vcu.edu | www.cpsd.vcu.edu

ADULT APPLICATION FOR SERVICES

Name: _____ Birthdate: _____ Age: _____
Last, First

Address: _____
Number/ Street / PO Box, Apt# 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 _____

Sex (assigned): Female Male Intersex _____

Gender identity: Female Male Genderqueer/Non-binary Transgender _____

Gender pronouns: She/Her He/Him They/Them Ze/Zir _____

Sexual orientation: Straight Lesbian/Gay Bisexual Queer Don't know _____

Student status: Full-time student (school: _____) Part-time student Not a student

Highest education level completed: None yet Grade school High school Trade/Technical school
 Associate's degree Bachelor's degree Master's degree Medical/Doctorate degree _____

Employment status: Student Employed full-time (occupation: _____)
 Employed part-time Not employed Disabled Retired _____

Relationship status: Single Divorced Married Partnered Separated Widowed _____

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

SERVICES

What services 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

Were you referred? Yes (agency or provider's name: _____) 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 responsible for paying fees (responsible party): _____

Responsible party's relationship to applicant: Self Parent Legal guardian Authorized representative

_____ Telephone #: _____

Total annual income: *Total income of all adult members in immediate household plus any additional income from child support or other sources.*

- | | | |
|---|---|---|
| <input type="checkbox"/> 0 to 10,000 | <input type="checkbox"/> 10,001 to 20,000 | <input type="checkbox"/> 20,001 to 30,000 |
| <input type="checkbox"/> 30,001 to 40,000 | <input type="checkbox"/> 40,001 to 50,000 | <input type="checkbox"/> 50,001 to 60,000 |
| <input type="checkbox"/> 60,001 to 70,000 | <input type="checkbox"/> 70,001 to 85,000 | <input type="checkbox"/> 85,001 or more |

Total number of dependents: _____ *Count non-working family members in the responsible party's immediate household.*

Is responsible party working with any university, school, or community agency that will pay fees? Yes No

Insurance: Private VA VCC Medicaid Medicare None *CPSPD neither files claims nor receives insurance payment.*

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 eating problems fears life adjustment problems relationship problems
 sleeping problems social problems substance abuse problems withdrawal

If any checked, for how long: _____

Have you experienced the following at school/work? (check all that apply) behavior problems detention/suspension
 fighting gang influence lack of friends learning disabilities poor attendance poor performance

If any checked, for how long: _____

Describe your current problems and concerns _____

Have you purposely hurt yourself? No
 Yes (describe) _____

Have you purposely hurt another person? No
 Yes (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 (describe) _____

Are you currently taking any medication? No
 Yes (names / dosages) _____

Primary-care doctor's name: _____ Telephone #: _____

What more do we need to know?

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EMAIL CONSENT AND SOCIAL MEDIA POLICY

This form contains important information about our policies regarding email communications and social media. Please read it carefully as it represents an agreement between you (I, your) and the Center for Psychological Services and Development (CPSD, we, us, our). Our staff and your clinician can answer your questions.

CPSD uses email primarily to schedule appointments but this limited use carries some risks, such as:

- Email can be immediately broadcast worldwide and received by many intended and unintended readers.
- Email senders can easily misaddress an email.
- Backup copies of email may exist even after the sender or recipient has deleted the original.
- Employers and on-line services have a right to archive and inspect email within their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce computer viruses.
- Email can be used as evidence in court.

HOW THE CPSD WILL HANDLE EMAIL COMMUNICATION

- We will not include sensitive information in emails and ask that you not email sensitive information to us.
- We will include all email messages from you, other than those for scheduling, in your clinical record.
- We may ask CPSD staff to email you regarding administrative matters including your billing account and your contact information.
- We may forward emails to CPSD staff members such as the receptionist.
- We will not forward emails to independent third parties without your written permission, except as authorized or required by law.
- We cannot guarantee that email will be read and responded to within any particular period of time.
- We do not accept email for emergencies or other time-sensitive matters.
- We strongly recommend the use of encrypted email. Our staff can explain the options available.
- We cannot take responsibility for the protection of personal email accounts.
- We will not engage in unlawful email communication.
- We ask to be informed if you change your email address.

MINOR CLIENTS

CPSD staff and clinicians do not communicate by email with clients under the age of 18.

If you are a parent/guardian consenting to email communication concerning your child, please sign as the parent/guardian and provide *your* email address.

We require a separate consent form from each parent/guardian who wishes to exchange emails with the CPSD regarding a minor client.

SOCIAL MEDIA POLICY

Text Messaging: CPSD staff and clinicians will not text message you, nor respond to text messages from you.

Social Media: CPSD staff and clinicians do not communicate with any of our clients through social media platforms like Twitter and Facebook. If staff or therapists discover that they have accidentally established an online relationship with you, they are required to dissolve that relationship immediately. This agreement will continue after you are no longer receiving services at CPSD.

Websites: The CPSD has a website that you are encouraged to access. If you have questions about any information on the website, discuss them with your clinician.

Web Searches: CPSD staff and therapists will not use web searches to gather information about you without your permission. If you encounter information about your clinician through web searches, or in any other fashion, please inform them so that any potential impact on your treatment may be discussed.

CONSENT

Client Name (please print) _____

Parent/Guardian or Authorized Representative Name (please print) _____

Relationship to client (please print) _____

____ (initial) I read and fully understand this consent form. I understand the risks of using email and I agree to the conditions outlined above. I understand that the CPSD does not accept email messages as emergency notification and does not guarantee a timely response or any response to email.

____ (initial) I understand that CPSD staff and therapists will not respond to text messages from me (or my child) and will not communicate with me (or my child) through social media, during and after treatment.

____ (initial) I understand that CPSD staff and therapists will not conduct web searches to gather information about me (or my child).

____ (initial) I have been given the opportunity to ask questions about the statements above and my questions have been answered to my satisfaction.

Check one to give or deny permission:

____ I give permission for email communication.

Email: (please print) _____

____ I do not give permission for email communication.

Client or Parent/Guardian/Representative Signature

Date