

**CHILD APPLICATION FOR PSYCHOTHERAPY SERVICES**

Thank you for your interest in WCSPP. We are committed to provide high-quality psychotherapy to people in need throughout Westchester, Rockland and Fairfield, CT counties as well as the Bronx. Your application will be considered thoughtfully, and we will do our best to pair your child with a therapist as quickly as possible. It takes approximately one week to process each application. Please be aware that we are not equipped to offer services to those in immediate crisis. If your child is in crisis, we recommend that you contact your local hospital emergency center. In the event that we are not able to assign your child to a clinician in one of our training programs, we will provide you with another referral. If you have any questions, please feel free to contact the Psychotherapy Service at 914-997-7500.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s age: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Home address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School and Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: Cell phone (mother):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell phone (father):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) occupation/employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents’ Relationship status (please circle):

Married Single Separated Committed Divorced Widowed

Family Members Living in Household (Name, Relationship to Child, Age):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you hear about WCSPP?

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Has your child had previous experience with outpatient psychotherapy? Yes No

If yes, when and with whom?

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WCSPP, 468 Rosedale Avenue, White Plains, NY 10605 T: 914-997-7500 F: 914-997-7501 www.wcspp.org info@wcspp.org

Has your child ever been hospitalized for a psychiatric illness? Yes No

If yes, when, where and why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever had suicidal thoughts (to the best of your knowledge)? Yes No

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever made a suicide attempt? Yes No

If yes, please specify number of attempts (when and how) and describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever exhibited dangerous behavior? Yes No If yes, please describe:

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Does your child abuse substances? Yes No If yes, please describe:

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Does your child have any medical problems or physical challenges? Yes No

If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child currently taking any medication, including psychiatric medication? Yes No

If yes, please list and describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have any academic or educational challenges? Yes No If yes, please describe:

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How would you describe the level of emotional support your child receives from family and friends?

(please circle)

Support from family: strong moderate low none

Support from friends: strong moderate low none

We will set your fee based on a sliding scale of your income, including family/partner income.

What is the combined weekly income of both parents?

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When are the best days and times for your child to be seen for appointments?

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What concerns you about your child at this time?

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When did this situation begin?

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What do you think may be contributing to your child’s difficulties?

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Please describe any other details about your child’s history or current life situation that you think may be relevant to his/her difficulties. This may include information about his/her pregnancy/birth/delivery, infancy, self-regulation, family/peer-relationships, history of losses, accidents or injuries, social activities/hobbies, etc.

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How do you hope the WCSPP Psychotherapy Service can be of help?

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have consented for my child to receive psychotherapy with a candidate. WCSPP candidates are masters or doctoral level clinicians enrolled in our postgraduate training programs. I understand that WCSPP provides education and training to candidates which involves clinical consultation or supervision with WCSPP faculty and other qualified mental health professionals regarding the services they provide. WCSPP is committed to maintain the utmost confidentiality.

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Signature Date

Please mail or fax completed application to:

WCSPP Attn: Administrator

468 Rosedale Ave, White Plains, NY 10605

T: 914-997-7500 F: 914-997-7501

E: info@wcspp.org W: [www.wcspp.org](http://www.wcspp.org)