William Alanson White Institute
Clinical Services
20 West 74th Street
New York, New York 10023
(212) 873-7070

Child and Family Center -- Clinical Services

Attached is the application for treatment in the Child and Family Center at the William Alanson White Institute. When your completed application is returned to us it will be processed as quickly as possible. The screening process consists of one to three interviews with the parent(s) or guardian(s) in order to clarify the nature of the difficulty and to collect information about your child's life history. After these interviews, the child will be seen for one or more diagnostic play sessions or interviews. One or more family sessions may also be indicated. Then the parent(s) will again be seen so that the results of the screening process and a treatment plan or referral can be communicated and discussed.

There are some limitations to our services, however, that are important for you to know in order to help you decide on seeking treatment here. Our fees are adjusted to help people with financial limitations and we have a sliding scale to cover the portion of the clinic fees not paid by your insurance. We unfortunately cannot accept Medicaid or managed care plans. (We do have a list of outside therapists that may accept these arrangements.) If educational and/or psychological testing and/or medication of the child are indicated and provided, an additional appropriate fee will be charged. Treatment is provided one to two times weekly. Family members may also be seen together or individually as indicated.

We would like you to know that our clinic facilities are limited. We hope that it will be possible for us to help you and assure you that if you file an application it will receive our careful consideration. However, we cannot see everyone who applies nor can we accept for treatment all those we do see in the screening process. Our occasional inability to match you with a therapist is no reflection on you or your child's need for or ability to profit from treatment. When therapy is not available at our clinic we will make every effort to find an acceptable alternative for you.

In the event that you have to change or cancel any of your screening appointments, we would appreciate as much notice as possible, since the time is set aside for you. Failure to use the time deprives someone else of an opportunity to be seen.

Please detach this information sheet from the application and hold on to it for future reference.

Revised 7/09

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APPLICATION FOR CHILD/ADOLESCENT PSYCHOTHERAPY

Date ___________________________

Name of person filling out application ____

Relationship to child ____________________ Does child live with you? _________

Is this your biological child ________ foster child ________ adopted child _____________

CHILD'S NAME _____________________________Male _______ Female ____________

Address _____________________________________ Phone (   ) ____________________

City ___________________________ State ____________________Zip _______________

Age ________ Date of birth _____________ Religion _________________________

Race and/or ethnicity ____

School ____ Grade _____________

Birthplace ________________ If not USA, how long in this country? _________________

Language used in the home ____

By whom were you referred? May we call and thank this person? Yes_____ No _____

Name:____ Institution:________________

Address:____ Phone:____________________

Family information

Who lives in your household?

Name	Age	Relationship

Mother’s name ____________ Age ________Religion ____________Birthplace _________

Years of school completed by mother ______ Marital status __________________________

Occupation ____________________________ Business phone (   ) ____________________

Is mother living or deceased? ______ (if deceased, child’s age when she died) _________

Father’s name _____________ Age ________ Religion ___________ Birthplace _________

Years of school completed by father _______ Marital status __________________________

Occupation ____________________________ Business phone (   ) ____________________

Is father living or deceased? _______(if deceased, child’s age when he died) ___________

Have parents ever been separated? ________ Divorced? ____________________________

If yes to either, please complete the following:

Age of child at time of parents’ separation or divorce _______________________________

If divorced, did father remarry? ___________ Child’s age at the time __________________

Is stepmother living or deceased? _________ If deceased, child’s age at the time _______

If divorced, did mother remarry? __________ Child’s age at the time __________________

Is stepfather living or deceased? __________ If deceased, child’s age at the time _______

If there are additional siblings, half-siblings, or step-siblings not living in child's primary household, please list them.

Name	Age	Relation	If applicable, date of death

Does the child spend a lot of time in any other relative's household? If so, please list everyone living in the other household.

Name	Age	Relation

Who takes care of the child most of the time? ____

____

Is there a family history of any of the following? If so, please check and tell which family member(s) and relation to child.

Alcoholism ______________________ Drug abuse ______________________
Gambling ________________________ Mental illness ____________________
Manic-depressive illness ___________ Panic disorder ____________________
Domestic violence ________________
Psychiatric hospitalization ____
Psychiatric medication ____

How would you describe your ability to control your anger?

*or other adults child lives with or visits the most

	Father*	Mother*
Very well	_____	_____
Okay, worry about it sometimes	_____	_____
Not well, sometimes smash objects	_____	_____
A problem, have hit people	_____	_____

Do you own a weapon?

	Father*	Mother*
Yes	_____	_____
No	_____	_____

If your child has received or is receiving psychological testing, educational testing, special education, tutoring, or help or consultation for personal, emotional, educational, or medical problems, please give the names, addresses and telephone numbers of the doctors, hospitals, schools, agencies, and/or individuals involved and the approximate dates of contact. No one will be contacted unless you give us your written permission.

____
____
____

Current problems

What difficulties are your child or family having that you would like help with? When, where and with whom do these difficulties occur the most? The least?

____
____
____
____
____

When and how did these difficulties begin? What changes have occurred in these difficulties over time?

____
____
____

How do you think we can help?

____
____
____

Where else have you gone for help with these difficulties? Please list dates and describe what happened. Has the child, family, or other family member(s) received therapy for this difficulty? Medication? Hospitalization?
____
____
____

Other professionals involved
Pediatrician's name ____

Pediatrician's address _________________________________ Phone ( ) _______________

Date of child's last physical exam ______________________ If no physical exam in the last year, we strongly advise you to have your child get one at this time.

Check if any of the follow occur or have occurred.

Violent behavior ___________ Sleep disturbances _______________Nightmares ________
Bed wetting _______________ Obsessions or compulsions ________Tantrums __________
Depressions _______________ Panic attacks ____________________ Tics ______________
Separation anxiety _________ School phobia ___________________Suicide attempts ____

Special fears (of what?) ____

____

Other ____

____

Early history

Were there any difficulties with mother's pregnancy with this child?

____

____

____

____

Were there problems at birth with child or mother?

____

____

____

____

Baby's birth weight _______________

When did child first Walk ____

Talk ____

Feed self ______________________________________

Accomplish toilet training ________________________

Describe any eating, sleeping or toilet problems in the past or present

____

____

____

Describe the child's present and past health, including serious illnesses and surgery. Mention any hospital stay, when it occurred and for how long.

____

____

____

Have there been any separations or disruptions in the child's life? Please describe events in the immediate or extended family such as serious illness, death, separation, divorce, or hospitalizations. Give dates and tell which family member(s) were involved.

____

____

____

____

Has your child suffered any trauma, abuse, or violent incidents? Please describe.

Social functioning

With whom in the household does the child get along best? Please explain.

With whom in the household does the child get along least? Please explain.

In what way(s) does the child misbehave? What is usually done when this happens? What has been tried that works? What doesn't work?

Does the child have friends? A best friend? What are the child's relationships with other children usually like?

Please describe child's school history.

School (play group, if relevant) Dates

For adolescent applicant to fill out

Please describe your present troubles in your own words. What were the circumstances and problems leading to these difficulties? How long have they existed and what are your reasons for seeking help at this time?

____ ____________________

Adolescent applicant’s signature Date

Please complete the following questions in order to help us determine your fee based on our sliding scale.

The fee established at the time of the initial interview is tentative and subject to review and adjustment at any time during treatment.

INCOME AND RESOURCES

Family's gross weekly income $________________ after taxes $ ___________________

Other income $ ____

Housing expenses $ ______________ Tuition expenses $ ____________________

Unusual debts, expenses, or financial obligations $ ______________________________

Do you have insurance that covers outpatient psychotherapy for your dependents with out-of-network providers? ____ ____ What is your insurance carrier? ________________
yes no

Please list name and relationship of those persons who are financially dependent on you.

Name Relationship

____
____
____
____