

**WESTCHESTER CENTER FOR THE STUDY  
OF PSYCHOANALYSIS AND PSYCHOTHERAPY**  
260 Stuyvesant Avenue, Rye, NY 10580  
(914) 967-1300

**CHILD / ADOLESCENT TREATMENT SERVICE APPLICATION**

**PARENT REPORT**

Name of person filing report: \_\_\_\_\_ Date: \_\_\_\_\_

Name of child: \_\_\_\_\_ Relationship to child \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work \_\_\_\_\_

Hours you can be reached / where: \_\_\_\_\_

Referred by: \_\_\_\_\_

School attending \_\_\_\_\_

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**Family Information**

Family members living in household (Names and ages):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What concerns you about your child? \_\_\_\_\_

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When did this situation begin? \_\_\_\_\_

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What do you think is the cause of your child's problem? \_\_\_\_\_

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Has your child received any previous help for his/her problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details and dates

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Does your child have any medical / physical problems? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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How do you hope WCSPP Treatment Service can be of help \_\_\_\_\_

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**Please detail any additional developmental, behavioral or school history that you feel important in understanding the present situation.**

You may want to include:

- Infant / pre school history
- Family / peer interaction
- School interests / performance
- Social activities / hobbies

**Please be advised that completion of this application does not guarantee admission to the WCSPP TREATMENT SERVICE. We will do our best to make an appropriate referral, but this may not always be possible.**

**WCSPP candidates are experienced and state licensed. As part of their post-graduate training, they will be continuously engaged in clinical consultations concerning the therapy of TREATMENT SERVICE patients.**

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Signature of person filling out this form

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Date of signature