



Date: ____/____/____ Child's Name (First, Last) _____

Gender (please circle): girl boy Date of birth: ____/____/____ Age: _____

Child's race/ethnicity: _____ Primary language spoken by child: _____

The Child HELP Partnership offers a variety of programs, providing services to children and families who have been through upsetting or traumatic events.

This child has experienced: (check all that apply)

____ Physical abuse/Excessive corporal punishment ____ Sexual Abuse ____ Domestic Violence ____ Traumatic death
____ Other (Please describe): _____

Description of traumatic event (e.g., CSA, CPA, DV, cause of death): _____

Was the physical abuse, sexual abuse, or other form of maltreatment substantiated? ____ Yes ____ No

Custodial agent (e.g., bio/foster parent(s), ACS, grandparent, other): _____

Name of caregiver(s) living with child: _____ phone: (____) _____

Caregiver's relationship to child: _____

Caregiver's address: _____

Caregiver's race/ethnicity: _____ Primary language spoken by caregiver: _____

Name of staff making referral: _____ phone: (____) _____

Name of staff's organization: _____

Name of ACS worker (if applicable): _____ phone: (____) _____

Name of ACS worker's supervisor (if applicable): _____ phone: (____) _____

Please check any symptom(s) that you think the child may be experiencing:

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Self-injurious behavior |
| <input type="checkbox"/> Posttraumatic stress disorder | <input type="checkbox"/> Substance dependence/abuse/use |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Aggressive behavior | _____ |

How did you find out about Child HELP Partnership?

Please FAX this form to Trish Batchelor, Intake Coordinator, at 718-990-1586, or call 718-990-2367 with questions.
Child HELP Partnership is located in the St. John University's Center for Psychological Services at:
152-11 Union Turnpike, Queens, NY 11367