

## **Harrisonburg-Rockingham CSB**

Thank you for expressing an interest in receiving mental health and/or substance abuse services from the Harrisonburg/Rockingham CSB or the McNulty Center for Children and Families.

Please complete the following enclosed forms:

- 1) Request for Service
- 2) Problem checklist
- 3) Emergency Medical/Health History Information

An intake appointment can be scheduled when you return these forms to the CSB at 1241 North Main Street, Harrisonburg, VA 22802 by mail or in person.

After the Intake, most adult clients will be referred to weekly group therapy or case management services. Some clients may be referred to our psychiatrist or nurse practitioner and prescribed medication. Medication management services are only available to clients who are participating in other CSB services. Therapy and case management is also available for children. In some cases, medication management may be available to children when other services are not planned.

Adults receiving therapy services will not usually be able to continue receiving medication through the CSB once they have completed their therapy. Staff will be available to help with the transition to other medication providers in the community. Individuals in case management services may receive long-term medication management.

We will contact you to schedule the intake appointment as soon as possible.

**Harrisonburg-Rockingham Community Services Board**  
**REQUEST FOR SERVICE**

**IDENTIFYING INFORMATION:**

Name: \_\_\_\_\_ Former/maiden name: \_\_\_\_\_

Street address: \_\_\_\_\_

City/town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN \_\_\_\_\_ Gender: \_\_\_\_\_

Parent/guardian name (if a minor) : \_\_\_\_\_

Have you come to the CSB before: \_\_\_\_\_ If yes, when? \_\_\_\_\_

Are you now a college student? \_\_\_\_\_ If so, where? \_\_\_\_\_

**INSURANCE INFORMATION:**

Do you have any type of Medicaid? \_\_\_\_\_ Medicare? \_\_\_\_\_

Other health insurance? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Employer of insured: \_\_\_\_\_

**INFORMATION ABOUT YOUR REQUEST:**

Did someone refer you to the CSB? \_\_\_\_\_ If yes, who? \_\_\_\_\_

Reason/problem for which you are seeking services: \_\_\_\_\_

What has been stressful to you recently? \_\_\_\_\_

Have you ever had mental health or substance abuse treatment in the past? \_\_\_\_\_

If so, where/when? \_\_\_\_\_

Are you requesting substance abuse services? \_\_\_\_\_ If so, are you pregnant? \_\_\_\_\_

HARRISONBURG-ROCKINGHAM CSB

Client's Name \_\_\_\_\_ Date \_\_\_\_\_

**Which of the following problems do you (or your child) need help with?**

- alcohol abuse
- drug abuse
- depression
- suicidal thinking
- hurting or cutting yourself
- thoughts of harming someone else
- intense anger/aggressive behavior
- irritability
- decreased interest in activities
- anxiety or nervousness
- excessive worrying
- panic attacks
- fears of being abandoned
- episodes of "spacing out"
- repetitive behavior (handwashing, checking, counting, etc)
- severe mood swings
- racing thoughts or feeling speeded up
- periods of high energy & decreased need for sleep
- trouble concentrating or paying attention
- problems with sleep
- poor appetite
- eating disorder/body image
- difficulty trusting others
- thoughts that others are trying to harm you
- hearing voices or seeing strange visions
- strange, unusual, or repetitive thoughts
- issues related to being abused
- abusing others
- sexual problems
- loss (death, divorce, separation)
- parenting
- arguing or conflict with others
- problems with authority
- problems at school
- none
- other \_\_\_\_\_

Clinician: \_\_\_\_\_

Date: \_\_\_\_\_



Do any of the following people have serious illnesses or chronic conditions?				
Parents	Yes _____	No _____	(specify) _____	_____
Siblings	Yes _____	No _____	(specify) _____	_____
Significant others in the same household	Yes _____	No _____	(specify) _____	_____

Do you have an advanced medical directive? Yes \_\_\_\_ No \_\_\_\_

Have you taken any prescription or over-the-counter medications during the past six months? *If **YES**, provide the following information:* Yes \_\_\_\_ No \_\_\_\_

Medication	Dosage	How long taken	Reason Taken	Prescribing Doctor

Have you ever used alcohol or other drugs? Yes \_\_\_\_ No \_\_\_\_  
*If **YES**, provide the following information:*

Type	Age of First use	Date of Last use	How Often	How Much	Method of Use

Sexual health or reproductive history that the agency should be aware of related to your request for Services  
 : \_\_\_\_\_

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Staff Person (if different from above): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of CSB Psychiatrist (if Medicare or Medicaid): \_\_\_\_\_ Date: \_\_\_\_\_