THE NEW YORK PSYCHOANALYTIC INSTITUTE
247 East 82nd Street
New York, New York 10028
(212) 879-6900

Application for Psychoanalysis

***** THIS APPLICATION WILL BE KEPT CONFIDENTIAL *****

NAME:

MAIDEN NAME (and other names by which known):

HOME ADDRESS:

TELEPHONE: Res:

EMAIL ADDRESS:

Bus:

AGE, WITH DATE OF BIRTH:

SEX:

HOW DID YOU FIND OUT ABOUT OUR TREATMENT CENTER?

OCCUPATION:

MARITAL STATUS (Single, married, separated, divorced, widowed; with dates of marriage/marriages, and age and sex of children):

Name and Address of spouse or other responsible relative:

PRINCIPAL COMPLAINT OR COMPLAINTS (List in order of importance, using single words, phrases, or short sentences.):

FAMILY BACKGROUND (Give ages of parents, brothers, sisters, brief mention of important illnesses -- mental or physical, occupations, marital status. If any are deceased, give age, cause of death, and year of death.):

OUTLINE OF OCCUPATIONAL HISTORY (List principal jobs, their nature and places, with dates.):

FINANCIAL (Include salary, name of insurance, other sources of income, and unusual expenses.):

EDUCATION (List schools attended, with dates; degrees, diplomas, or highest grade completed.):

GEOGRAPHIC (Include place of birth and outline of principal changes of place thereafter.):

MEDICAL (List, with dates, all important illnesses or injuries -- medical or surgical. Give names and addresses of doctors or hospitals by whom treatment was conducted.):

PSYCHIATRIC (List, with dates, names, addresses, and fees paid, all consultations and previous psychotherapy or psychoanalysis, including consultations with psychologists, social workers or guidance counselors. Also list applications in process with other psychiatric clinics. Please also list previous applications to our Treatment Center.):

THE NEW YORK PSYCHOANALYTIC INSTITUTE

247 East 82nd Street, New York, NY 10028

Name of Applicant: ______________________________

INFORMED CONSENT

I understand that the Treatment Center of the New York Psychoanalytic Institute may contact the physicians, therapists, hospitals, and social agencies previously mentioned. I authorize the Treatment Center to make such inquiries. I authorize the professionals and agencies previously mentioned to answer any inquiries that the Treatment Center may make in connection with this application. In addition, I authorize any examiner for the Treatment Center to make a full report to the Treatment Center of his or her findings, diagnosis and recommendations. In order to facilitate appropriate referrals, I authorize the Treatment Center to fully communicate with and to provide all necessary information to other physicians, therapists, hospitals, or social agencies.

Signed: ______________________

Dated: ______________________

If applicant is under 18 years of age, please have parent or guardian sign.

I understand that, if recommended for psychoanalytic treatment, it will be necessary to make available one hour daily, four or five days a week, for the treatment. With this in mind, **please list your potential time availabilities** for treatment during the week (M-F).

Times:

Signed: ______________________

Dated: ______________________

If applicant is under 18 years of age, please have parent or guardian sign.

I understand that patients accepted for this program will be treated or tested by therapists who are in training and who are supervised in their analysis work by experienced analysts on the faculty of The New York Psychoanalytic Institute and Society.

Signed: ______________________

Dated: ______________________

If applicant is under 18 years of age, please have parent or guardian sign.