

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

Application for Psychotherapy and/or Psychological Testing

THIS APPLICATION WILL BE KEPT CONFIDENTIAL

NAME:

MAIDEN NAME (and other names
by which known):

HOME ADDRESS:

TELEPHONE: Res:

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.):

Referral for (check a. or b. or both):

a) Evaluation for possible treatment _____

b) Psychological testing _____

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, 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

Treatment Center

Patient's Name: _____
(please print)

INFORMED CONSENT

I understand that the Treatment Center of the New York Psychoanalytic Institute will write to 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 patients accepted for this program will be treated or tested by therapists who are in training and who are supervised in their 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.

All applicants will be considered without regard to race, color, religion, national origin, age, sex, or marital status. The Treatment Center has a policy of nondiscrimination because of disability, for persons otherwise qualified, in accordance with New York and Federal law.

3/04