nypsi
New York Psychoanalytic Society & Institute
247 East 82nd Street, NY, NY 10028-2701 • 212.879.0196 • **www.nypsi.org**

Adult Application for Evaluation for Psychoanalysis, Psychotherapy, and/or Psychological Testing

This application will be kept confidential.

SALUTATION: ☐ DR. ☐ MR. ☐ MRS. ☐ MS. ☐ PROFESSOR

FIRST NAME _____ SURNAME _____

MAIDEN NAME (AND/OR OTHER NAMES BY WHICH KNOWN): _____

HOME ADDRESS _____

_____

HOME TELEPHONE _____ OFFICE TELEPHONE _____ MOBILE TELEPHONE _____

EMAIL ADDRESS _____

DATE OF BIRTH (MONTH / DAY / YEAR) _____

CURRENT AGE _____ GENDER _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SIGNIFICANT OTHER ☐ WIDOWED

DATES OF MARRIAGE / MARRIAGES _____

AGE AND GENDER OF CHILDREN _____

_____

OCCUPATION _____

NAME AND ADDRESS OF SPOUSE OR OTHER RESPONSIBLE RELATIVE(S) _____

_____

_____

REFERRAL FOR (PLEASE CHECK ALL THAT APPLY): ☐ PSYCHOANALYSIS ☐ PSYCHOTHERAPY ☐ TESTING

Principal complaint or complaints

Describe as best you can the nature of the problems that you are seeking help for, their duration and what you know of their origins.

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 start/end dates.

Financial
Include salary, name of health insurance, other sources of income, and unusual expenses.

Education
List schools attended, from most recent to earliest, with dates attended, degrees/diplomas earned, or highest grade completed.

Geographic
Include city/country of birth and outline principal changes of place thereafter up until present day.

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 psychotherapies and analyses, including consultations with psychologists, social workers, or guidance counselors, as well as the dates and locations of all psychiatric hospitalizations and emergency room visits for psychiatric symptoms. Please indicate whether you are taking or have taken psychotropic medication and which medications. Also list applications in process with other mental health clinics, as well as previous applications to the NYPSI Treatment Center.

How did you find out about the Treatment Center at NYPSI?

Informed Consent

I UNDERSTAND that the Treatment Center of the New York Psychoanalytic Society & 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.

DATE SIGNATURE OF APPLICANT

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 (Monday through Friday).

AVAILABLE TIMES

DATE SIGNATURE OF APPLICANT

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 clinical work by experienced analysts who are members of New York Psychoanalytic Society & Institute.

DATE SIGNATURE OF APPLICANT

Please send completed form and processing fee of **$50**, payable to NYPSI, to:

New York Psychoanalytic Society & Institute
247 East 82nd Street, New York, NY 10028-2701
attn: Treatment Center Coordinator

FAX: 212.879.0588
EMAIL: tc@nypsi.org