nypsi
New York Psychoanalytic Society & Institute
247 East 82nd Street, NY, NY 10028-2701 • 212.879.6900 • **www.nypsi.org**

Child/Adolescent Application for Evaluation for Psychoanalysis, Psychotherapy, and/or Psychological Testing

This application will be kept confidential.

CHILD / ADOLESCENT'S FIRST NAME _____ SURNAME _____

PARENT / GUARDIAN'S FIRST NAME _____ SURNAME _____

PARENT / GUARDIAN'S FIRST NAME _____ SURNAME _____

HOME ADDRESS _____

_____

HOME TELEPHONE _____ MOBILE TELEPHONE _____

EMAIL ADDRESS _____

DATE OF BIRTH (MONTH / DAY / YEAR) _____

CURRENT AGE _____ GENDER _____

SCHOOL AT WHICH YOUTH IS ENROLLED _____

GRADE LEVEL _____

NAME / ADDRESS / HOME TELEPHONE / CELLPHONE OF RESPONSIBLE RELATIVE(S) _____

_____

_____

_____

Referral for (please check one or both):

☐ Evaluation for possible treatment

☐ Psychological testing

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

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. Indicate marital status of parents and whether living together or apart.

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 of 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 or analyses, 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.

Informed Consent

I UNDERSTAND that the Treatment Center of the New York Psychoanalytic Society & 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, school officials, teachers, or social agencies.

DATE SIGNATURE OF APPLICANT

DATE SIGNATURE OF PARENT/GUARDIAN

DATE SIGNATURE OF PARENT/GUARDIAN

IF APPLICANT IS UNDER 18 YEARS OF AGE, PLEASE HAVE PARENTS OR GUARDIANS SIGN.

If the child has a parent or guardian who has not signed this form, kindly explain the reason. Comments:

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 Society & Institute.

AVAILABLE TIMES

DATE SIGNATURE OF APPLICANT

DATE SIGNATURE OF PARENT/GUARDIAN

DATE SIGNATURE OF PARENT/GUARDIAN

IF APPLICANT IS UNDER 18 YEARS OF AGE, PLEASE HAVE PARENTS OR GUARDIANS SIGN.

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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