

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 CHILD 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 their important illnesses—mental or physical; 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 of parent(s)

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 by the child/adolescent, from most recent to earliest, with dates attended, degrees/diplomas earned, or highest grade completed.

Geographic

Include city/country of birth and summarize principal changes in residence up to the present day.

Medical

List, with dates, all important illnesses or injuries—medical or surgical. Include names and addresses of the doctors or hospitals that provided treatment.

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.

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

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