

## 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. Trainees provide clinical services only, do not testify in court, and do not conduct evaluations for legal purposes. Sessions may not be recorded without the therapist’s knowledge and consent.

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  
EMAIL: [tc@nypsi.org](mailto:tc@nypsi.org)