

Sondheim Clinic Application for Evaluation for Psychoanalysis, Psychotherapy, and/or Psychological Testing

Are you a lyricist, composer, or playwright of the theater"? If yes, please provide specifics below.

If no, please fill out our regular Treatment Center application that can be found on our website.

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?

Additional Information

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 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