

**WESTCHESTER CENTER FOR THE STUDY
OF PSYCHOANALYSIS AND PSYCHOTHERAPY**

260 Stuyvesant Avenue, Rye, NY 10580

(914) 967-1300

FAX: (914) 967-2700

TREATMENT SERVICE APPLICATION

Date: _____

Name: _____ Sex: M ___ F ___

Referred by: _____

Date of birth: _____ Age: _____

Home Address: _____

Telephone: Home: _____ Work _____

Hours you can be reached / where: _____

Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____

Present Occupation / School: _____

Business Address: _____

Schools Attended / Degrees Earned: _____

Financial Information

SS#: _____ Insurance Carrier: _____

Family Weekly Income: _____

If married, name of spouse: _____

Date of birth: _____

SS#: _____ Insurance Carrier: _____

Family Information

Family members living in household (Names and ages):

Previous outpatient therapy contact: Yes _____ No _____

If yes, where? _____

when? _____

Have you been hospitalized for psychiatric treatment? Yes _____ No _____

If yes, where and when: _____

why: _____

Have you had a history of alcohol or substance abuse? Yes ___ No ___ Specify _____

Are you currently using substances? Yes ___ No ___ If yes specify _____

Have you ever thought of suicide or made an attempt? Yes ___ No ___

If yes, when and how _____

Are you currently on any form of medication or tranquilizers? Yes _____ No _____

If yes, please indicate name and dose: _____

Do you have any medical problems? Yes _____ No _____

If yes, please specify treatment: _____

Please give your reasons for seeking therapy at this particular time. Describe your problems, how long they have existed and what you see as your goal in therapy.

Please be advised that completion of this application does not guarantee admission to the WCSPP TREATMENT SERVICE. We will do our best to make an appropriate referral, but this may not always be possible.

WCSPP candidates are experienced and state licensed. As part of their post-graduate training, they will be continuously engaged in clinical consultations concerning the therapy of TREATMENT SERVICE patients.

Signature of person filling out this form

Date of signature