Karen Horney CLINIC

For psychoanalytic treatment, training and research

329 EAST 62ND STREET • NEW YORK, NY 10021 • (212) 838-4333

In association with The American Institute for Psychoanalysis

NAME ____

Last Name First Name Middle Maiden Name

HOME ADDRESS ________________________________ **APT.#** __________

CITY ____________________________ **STATE** __________ **ZIP CODE** ____________

HOME PHONE # ____________________ **WORK PHONE #** ______________________

S.S. # ___________________________ **D.O.B.** _____/_____/_____ **AGE** ____________

GENDER: ☐ Male ☐ Female **WEIGHT** _______________ **HEIGHT** _______________

U.S. CITIZEN: ☐ Yes ☐ No

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EDUCATION: ☐ Grammar School ☐ High School ☐ College ☐ Other ____________

IF PRESENTLY ATTENDING SCHOOL, PLEASE STATE:

Name of school ____

Address ____

EMPLOYMENT STATUS:

Occupation ______________________________ How long ______________

Employer ____

Address ____

PLEASE STATE THE HOURS AND DAYS YOU WILL BE AVAILABLE FOR APPOINTMENTS, WHICH MAY BE AS OFTEN AS THREE TIMES A WEEK.

WOULD YOU BE INTERESTED IN SATURDAY APPOINTMENT ?: ☐ Yes ☐ No

____

____

LIST OTHERS IN THE HOME:*(Including children.)*

Name	Relationship	Sex	Age

LIST PREVIOUS THERAPY:*(Therapists, Clinics, Hospitalizations.)*

Name	Address	Dates

LIST PRESENT THERAPY:*(Therapists, Clinics, Agencies with Whom You Have an Application at Present.)*

MILITARY STATUS AND RECORDS:

HOW DID YOU HEAR ABOUT THE KAREN HORNEY CLINIC ?*(Source of referral.)*

STATUS OF CURRENT HEALTH:

1) Current Illnesses ______________________________

____

____

2) Chronic Conditions ______________________________

____

____

PAST HEALTH HISTORY:

1) Significant Illnesses ______________________________

____

____

2) Hospitalizations ______________________________

____

____

3) Accidents ______________________________

____

____

SIGNIFICANT FAMILY ILLNESSES:*(If NONE, state so)*

____

____

____

CURRENT MEDICATIONS:*(Including Dosage, If NONE state so)*

Medication	**Mg**	**Dosage**

MONTHLY BUDGET FORM

Family Information

INSURANCE BENEFITS INFORMATION

Please Make Sure Both Parts Of This Form Are Completed.

PATIENTS NAME ____

NAME OF INSURANCE COMPANY ____

ADDRESS OF INSURANCE COMPANY ____

CITY _____________________________________ **STATE** _________ **ZIP CODE** ________________

POLICY # _________________________________ **TELEPHONE #** ____________________________

COVERAGE FOR PSYCHOTHERAPY PER YEAR $ ____

INSURANCE COVERAGE FOR: ☐ Myself ☐ Spouse ☐ Child

MEDICAID # ____ **SEQ #** ______________

MEDICARE # ____ **EFFECTIVE DATE** ______________

IN CONSIDERATION OF OUT-PATIENT CARE AND TREATMENT RENDERED TO:

☐ Myself ☐ Spouse ☐ Child

I____ , HEREBY ASSIGN THE INSURANCE BENEFITS TO WHICH I MAY BE ENTITLED TO THE KAREN HORNEY CLINIC, INC. AND I AUTHORIZE PAYMENT OF THESE TO BE MADE DIRECTLY TO SAID CLINIC. I AUTHORIZE THE KAREN HORNEY CLINIC, INC. TO COMMUNICATE ANYAND ALL PERTINENT DATA TO MY INSURANCE COMPANY REGARDING THIS ASSIGNMENT.

____

Signature of Policy Holder **Date**

FORM A