



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

CHILD AND ADOLESCENT SERVICES APPLICATION

CHILD'S NAME _____

Last Name

First Name

HOME ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ S.S.# _____

NICKNAME _____ GENDER : Male Female

DATE OF BIRTH ____ / ____ / ____ PLACE OF BIRTH _____

SCHOOL _____ GRADE _____

MOTHER'S NAME _____ BIRTHPLACE _____

FATHER'S NAME _____ BIRTHPLACE _____

DIFFICULTIES YOUR CHILD PRESENTS NOW:

DOES YOUR CHILD HAVE ANY SERIOUS PHYSICAL PROBLEMS ? Yes No

If Yes, please explain: _____

HOW DID YOU HEAR ABOUT KAREN HORNEY CLINIC ? _____

REFERRED BY: _____

LIST PREVIOUS THERAPY:(*Therapists, Clinics, Hospitalizations, dates and length of treatment.*)

Name Address Dates

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

REMARKS:*(Please State How You Feel We Might Be of Help, And Any Additional Information You May Wish To Give.)*

LIST THOSE LIVING AT HOME:*(Including children.)*

Name	Gender	Birth Date	Birth Place	Relationship
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____

LIST OTHER CHILDREN LIVING OUTSIDE FOME:

_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____

PARENTS EDUCATION:*(Enter last grade completed.)*

MOTHER: Grammar School _____ High School _____ College _____ Other _____

FATHER: Grammar School _____ High School _____ College _____ Other _____

PARENTS MARITAL STATUS: *(Please check appropriate box and give the dates.)*

Married Separated Divorced Legal Separation Widowed

Date _____

EMPLOYMENT STATUS:

MOTHER: Employed Unemployed

Occupation _____ How long _____

Employer _____

Address _____

FATHER: Employed Unemployed

Occupation _____ How Long _____

Employer _____

Address _____

MEDICAL COVERAGE: *(Insurance, Medicaid, Medicare, Crime Victims Board, Workers Compensation, Other.)*

PATIENT PHYSICAL HEALTH RECORD:*(To Be Completed By Parent / Guardian.)*

1) Has your child ever been ill to the point that special medical attention has been required ? Yes No

If Yes, please explain: _____

2) Has your child ever been hospitalized ? Yes No

If Yes, please indicate:*(Including Name of the Hospital, Reason and Dates.)* _____

3) Has your child ever required surgery? Yes No

If Yes, please indicate:(Including Name of the Hospital, Reason and Dates.) _____

4) Has your child received medicine of any type ? Yes No

If Yes, please indicate:(Including Doctors Name, Medicine, Reason and Dates.) _____

5) Does your child have any heredity, congenital or chronic acquires abnormality ? Yes No

If Yes, please explain: _____

6) Has child or mother had any of the following at birth:(Please Check One.)

	Yes	No
Blue Baby	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding (<i>abnormal maternal bleeding</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Labor	<input type="checkbox"/>	<input type="checkbox"/>
Forceps Delivery	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia for Delivery	<input type="checkbox"/>	<input type="checkbox"/>
Rh Problems	<input type="checkbox"/>	<input type="checkbox"/>
Birth Abnormality	<input type="checkbox"/>	<input type="checkbox"/>

If Yes, please explain: _____

Any time after the first fourteen days of life, did your child have the following: *(Please Check One.)*

	Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Injure Easily	<input type="checkbox"/>	<input type="checkbox"/>
Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
Growth Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Movements	<input type="checkbox"/>	<input type="checkbox"/>

INFECTIONS:

	Yes	No
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|-----------------------|--------------------------|--------------------------|
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| Diphtheria | <input type="checkbox"/> | <input type="checkbox"/> |
| Pertussis | <input type="checkbox"/> | <input type="checkbox"/> |
| Strep Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| German Measles | <input type="checkbox"/> | <input type="checkbox"/> |

7) Do you have a regular pediatrician ?

Name _____

Address _____

Telephone # _____

8) Vaccination Records:

- | | Yes | No | | |
|------------------|--------------------------|--------------------------|-----------------------------------|-----------------------------------|
| Polio | <input type="checkbox"/> | <input type="checkbox"/> | | |
| DPT | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> | | |
| T.B. Test | Date of last one _____ | | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative |
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Smallpox | <input type="checkbox"/> | <input type="checkbox"/> | | |

9) Has your child traveled abroad within the last 18 month ? Yes No

If Yes, please specify: *(When and Where.)* _____

10) Has your child received routine dental care ? Yes No

11) Has anyone in the family ever had the following ?

- | | Yes | No |
|----------------------------|--------------------------|--------------------------|
| T.B. (Tuberculosis) | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Birth Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| Learning Disability | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes, please explain: _____

CHILD AND ADOLESCENT SERVICES PROGRAM

CONSENT TO EVALUATION AND TREATMENT FORM

I herewith consent to the study and treatment of my child

_____ by the Karen Horney Clinic.
Child's Name

Signature (Parent, Legal Guardian)

Date

IF CHILD IS AGE 12 OR OVER THE FOLLOWING MUST ALSO BE SIGNED BY HIM / HER.

I herewith consent to study and treatment performed by the Karen Horney Clinic.

Signature

Date