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

MEDICAL FORM - SELF-REPORT

(TO BE COMPLETED BY PATIENTS)

Dear Patient - It is important that you provide us with your medical information in order to receive quality integrated treatment. Please complete the below form online. You can also download and/or print out this form and return it to: Attn: Dr. Henry Paul, Karen Horney Clinic, 329 E. 62nd Street, New York, NY 10065. Fax: 212-838-7158; Email: TheClinic@karenhorneyclinic.org. Please email us if you would like a hard copy of this form mailed to you.

Individual's Name (First MI Last):	**DOB:**	**Date:**

Doctor's Name:	Address:	Phone Number:	**Date of Last Exam**:
Dentist's Name:	Address:	Phone Number:	**Date of Last Exam**:

Has a Doctor EVER told you that you had any of the following conditions?

Condition	**Check One**		**Currently Under a Doctor's Care**		**Comment**
	Now	Past	Yes	No	
Alzheimer's Disease or Dementia	☐	☐	☐	☐	
Blood Sugar-High	☐	☐	☐	☐	
Blood Pressure (High)	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Deafness or other hearing impairment	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐	☐	☐	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐	☐	☐	

Mobility Impairment	☐	☐	☐	☐	
Other Cardiac Condition	☐	☐	☐	☐	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐	☐	☐	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐	☐	☐	

Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐	☐	☐	
Sight Impairment	☐	☐	☐	☐	
Speech Impairment	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Traumatic Brain Injury	☐	☐	☐	☐	
Weight (Obesity, Unexplained Gain or Loss)	☐	☐	☐	☐	
Other physical related health conditions	☐	☐	☐	☐	

CURRENT Medication Information ☐ **None**

(Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?		Prescriber
				Yes	No	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Additional:

Medication HISTORY Information **None** ☐

(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?		Prescriber
				Yes	No	
				☐	☐	
				☐	☐	
				☐	☐	

Additional - Are there any medications you would like to avoid taking in the future?:

Allergies/Drug Sensitivities None ☐

☐ Food (specify):

☐ Medicine (specify):

☐ Latex / ☐ Other (specify):

Medical hospitalizations/significant operative and invasive procedures?

☐ No ☐ Yes If yes, complete information below:

Hospital	Date	Reason

Comments:

For Women Only

Currently pregnant?

☐ No ☐ Yes - If yes, expected delivery date:

Are you currently breastfeeding? ☐ No ☐ Yes

Receiving pre-natal healthcare?

☐ No ☐ Yes – If yes, indicate provider:

Any significant pregnancy history?

☐ No ☐ Yes – If yes, explain:

Menstruation

Last menstrual Period Date:

Menstrual Pain: ☐ No ☐ Yes

Menstrual Irregularities: ☐ No ☐ Yes ☐ Other:

Pre-menstrual symptoms: ☐ No ☐ Yes

Polycystic Ovary Syndrome? ☐ No ☐ Yes

If yes, Indicate provider:

For Children Only

Immunizations: Has the child or adolescent been immunized for the following diseases? Please check all that apply.

☐ Chicken Pox ☐ Diphtheria ☐ German Measles (rubella) ☐ Hepatitis B ☐ Measles ☐ Mumps

☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

All immunizations up to date? ☐ Yes ☐ No – Comments:

Prenatal exposure to Alcohol or other Drugs? ☐ Yes ☐ No – Comments:

Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):

Reviewed By:

Printed Name of Therapist	Signature of Therapist	Date
Printed Name of Psychiatrist	**Signature of Psychiatrist**	**Date**