

Thank you for taking the time to fill out this application for treatment at the William Alanson White Institute. Our goal is to match you as quickly as possible with a therapist. We will process your completed application within two weeks. Please note that treatment is by appointment only and we are unable to offer crisis intervention. If you need an immediate consultation, we recommend that you contact your local hospital emergency center.

Beginning psychotherapy is a big step and we would like to make the process as comfortable as possible. There are some limitations to our clinic that are important to know in helping you decide whether to seek treatment here. Our fees are adjusted to help people with financial limitations, and we have a sliding scale to make treatment affordable. Unfortunately, we cannot accept Medicaid, Medicare, or managed care plans. Since our facilities are limited, we cannot see everyone who applies, and we may have periods when our waiting time for a therapist may be too long for your needs. If we cannot assign you a clinic therapist, we will provide you with other referrals. Please know that our inability to match you with a therapist is not a reflection of your ability to benefit from treatment.

When fee is not an issue, or an individual wants to use health insurance/manage care, we have a list of Institute graduate therapists here.

WAWI abides by HIPAA privacy guidelines. This means that after we receive your application, we will treat it with extreme care to protect your privacy. As an applicant, you may email your application with the understanding that email is not a private or secure system.

Email application to Leila Sosa, our Clinic Administrator, at l.sosa@wawhite.org or send through postal mail to:

William Alanson White Institute
Clinical Services
20 West 74th Street
New York, NY 10023

Please detach this letter and retain for future reference.

Best regards,
Karen Chuck, JD, LCSW-R
Director of Clinical Services

Date: _____ Name: _____

Please call (212) 873-0725 Ext. 25 if you have any questions about our clinic.

Please check which service is of interest:

- ▢ **PSYCHOTHERAPY SERVICE:**

  Provides individual psychotherapy, once or twice per week, up to forty weeks. Sessions are available from 8:00 a.m. - 9:00 p.m. After forty weeks, you may decide with your therapist if you would like to continue in the therapist's private practice.

- ▢ **PSYCHOANALYTIC SERVICE:**

  Provides low-cost treatment for people wanting to work intensively for a minimum of three times per week for one to two years. Patients may be seen in the clinic or therapist's private office. Fees are adjusted to the patient's resources and financial circumstance.

SPECIALTY SERVICES:

Provides reduced fee services for treatment in specialty services. These programs operate separately from Clinic services and have different fee and admission criteria. All applications are considered for admission to the Clinic's general psychotherapy and psychoanalysis services. Please indicate if, in addition to admission to the Clinic, you would like your application to be considered for referral to a specialty service.

- ▢ Couples Treatment
- ▢ Eating Disorders, Compulsions and Addictions
- ▢ LGBTQ+ Psychotherapy Service
- ▢ Psychoanalytic Psychotherapy for Artists

Before initiating psychotherapy, it is essential that you have a complete physical exam in order to rule out any medical complications. Please let us know the date of your most recent physical and the results of the exam:

Physician: _____ Date of Exam: _____

CLINICAL SERVICES APPLICATION

Date:

Last Name: First Name: MI

What name do you prefer to be called?

Home Address:

City: State: Zip Code:

Mailing Address:

City: State: Zip Code:

E-Mail Address

☐ *It is okay for my email to be used for administrative purposes.*

Cell Phone: Work Phone:

☐ *It is ok to call my cell phone* ☐ *It is ok to call my work phone*

Emergency Contact:

Name: Phone Number:

Referred by (individual, agency, hospital):

Name:

Address:

City: State: Zip Code

▢ I require wheelchair access

Are you able to schedule appointments **between 9:00 am and 5:00 pm?**

▢ Yes ▢ No

If No, which hours may be possible:

▢ Before 9:00 am ▢ After 5:00 pm

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1) Date of Birth: _____ 2) Age at last birthday: _____

3) How would you describe your gender identity? Check all that apply:

▢ Male ▢ Female ▢ Nonbinary ▢ Cisgender ▢ Transgender ▢ Agender

▢ Gender nonconforming ▢ Other (Please Specify) _____

Your preferred pronouns: _____

4) How would you identify your sexual orientation?

▢ Hetero/Straight ▢ Bisexual ▢ Gay/Lesbian ▢ Asexual ▢ Queer

▢ Questioning ▢ Other (Please Specify)

_____

5) Ethnicity (Check all that apply):

▢ American Indian or Alaskan Native ▢ Black /African American ▢ Hispanic/Latin

▢ Asian / Pacific Islander ▢ White / Caucasian ▢ Other (please specify)

_____

6) Highest level of education completed:

▢ Graduate training (masters or doctorate) ▢ College (received four-year academic degree)

▢ High School/Trade School ▢ Eighth Grade

7) Are you currently attending school? (If **Yes**, specify school/major): _____

▢ Full-Time ▢ Part-Time ▢ Not a student

8) Are you currently employed? (If **Yes**, specify field): _____

▢ Working Full-Time ▢ Working Part-Time ▢ Volunteer Work ▢ Unemployed

▢ Other (please specify): _____

9) Relationship Status:

▢ Single ▢ Married/ Life Partner ▢ Separated ▢ Divorced ▢ Widowed ▢ Polyamory

10) How many people are living in your household? Include spouse, partner, parents, siblings, children, and roommates.

Relationship:	Age:	Relationship:	Age:

11) My relationships with family members (check one):

▢ Provide extensive emotional support.

▢ Provide an adequate amount of emotional support with occasional conflict.

▢ Provide less than adequate amount of emotional support with frequent conflict.

▢ Do not provide emotional support.

▢ No contact with family.

12) My relationships with friends (check one):

- ▢ Provide extensive emotional support.
- ▢ Provide an adequate amount of emotional support with occasional conflict.
- ▢ Provide less than adequate emotional support with frequent conflict.
- ▢ Do not provide emotional support.
- ▢ No friends.

13) Please describe any relevant medical or emotional history of your parents and siblings:

14) Please check all the reasons you are seeking psychotherapy:

▢ Anxiety
▢ Health status of myself
▢ Abrupt change in mood
▢ Bereavement
▢ Confusion about self-image or goals, etc.
▢ Decreased performance at work, home, or school
▢ Depression
▢ Dissociation
▢ Health status of someone I care about
▢ Memory problems or cognitive decline
▢ Relationship problems
▢ Planning the future
▢ Psychosis
▢ Concerns about abuse (eg. physical, emotional, etc.):
▢ Aftermath of a trauma (specify):
▢ Eating Disorder (specify):
▢ Substance use/abuse in self (check to specify: ▢ past / ▢ present)
▢ Substance use/abuse in others (check to specify: ▢ past / ▢ present)

▢ Other (specify):

15) Have you been in psychotherapy previously?

▢ No ▢ Yes, Once ▢ Yes, 2-4 times ▢ Yes, 5+ times

*If **yes**, when were you most recently in psychotherapy?*

▢ Within the last 6 month ▢ 6-12 months ▢ 12-24 months ▢ Over 2 years ago

15a) How many different therapists have you worked with?

16) What was the longest time you spent in any one psychotherapy?

☐ Less than 1 year ☐ 1+ year ☐ 2+ years ☐ More than 4 years

17) Why did you stop therapy?

18) Please list your most recent therapists (WE WILL NOT CONTACT THEM WITHOUT YOUR CONSENT).

Name:

Address:

City: State: Zip Code:

Name:

Address:

City: State: Zip Code:

19) Are you taking any medication? ▢ No ▢ Yes

*If **Yes**, please specify medications and dosage*:

20) Who currently prescribes your medication?

▢ Primary Care Physician ▢ Psychiatrist ▢ Nurse Practitioner ▢ Other (specify):

21) When did you last meet with your provider to review your medications?

22) Have you ever been hospitalized for emotional or mental problems?

▢ No ▢ Yes *(please specify number of hospitalizations):*

*If **Yes**, when was your most recent psychiatric hospitalization?*

▢ Within the last 6 months ▢ 6-12 months ▢ 12-24 months ▢ Over 2 years ago

At what age(s)?

23) Have you ever had suicidal thoughts?

▢ Never ▢ Occasionally ▢ Sometimes ▢ Often ▢ Frequently

24) Have you ever made a suicide attempt?

▢ No ▢ Yes *(please specify number of attempts):*

*If **Yes**, when was your last suicide attempt?*

▢ Within the last 6 months ▢ 6-12 months ▢ 12-24 months ▢ Over 2 years ago

At what age? _____

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25) Are you **currently** using non-prescription drugs? ▢ No ▢ Yes

26) Have you used non-prescription drugs **in the last year?** ▢ No ▢ Yes

*If **Yes** to 25 or 26, please specify **type of drug** and **frequency** of use*:

_____

27) Do you drink alcohol? ▢ No ▢ Yes

*If **Yes**, please specify* amount: _____ Frequency/Week: _____

28) Do you ever wonder if you have a problem with drugs or alcohol?

▢ No ▢ Yes ▢ Uncertain

29) Have you ever been treated for a drug or alcohol problem?

▢ No ▢ Yes *(specify program and date)* _____

30) Do you currently smoke cigarettes?

▢ No ▢ Yes *(specify packs per day)* _____

31) Do you currently restrict calories?

▢ No ▢ No, but I have in the past. ▢ Yes

32) Do you binge on food, purge, or use laxatives?

▢ No ▢ No, but I have in the past ▢ Yes *(specify frequency/week)*

33) Do you currently overexercise?

▢ No ▢ No, but I have in the past ▢ Yes

*If **Yes** to 25-33, please describe: Are you now in a 12-step program? (eg., A.A., N.A., O.A., S.A., S.I.A.)*

▢ No ▢ Yes *(specify program)*

34) Have you ever been in a 12-step program? (eg., A.A., N.A., O.A., S.A., S.I.A.)

▢ No ▢ Yes *(specify program and date)*

35) Do you have any other behaviors that you have concerns about? If **Yes**, specify here:

Internet and Social Media

How many hours per day do you spend online (not including work/school)?

- [ ] Less than 1 hour
- [ ] 1-2 hours
- [ ] 3-5 hours
- [ ] 6-8 hours
- [ ] More than 8 hours

Which of the following platforms do you use regularly?

- [ ] Instagram
- [ ] TikTok
- [ ] Facebook
- [ ] X (Twitter)
- [ ] Reddit
- [ ] YouTube
- [ ] Discord
- [ ] Online Forums
- [ ] Dating Sites
- [ ] Pornography
- [ ] Gaming
- [ ] AI searches
- [ ] AI companions
- [ ] AI therapist
- [ ] Other (please list in the box below)

Have you ever tried to reduce or stop using the internet but found it difficult?

- [ ] Yes
- [ ] No

(*If yes, what made it difficult?*)

Have you ever felt worse after spending time online or on social media?

- [ ] Never
- [ ] Rarely
- [ ] Sometimes
- [ ] Often
- [ ] Always

Has your online activity interfered with any of the following?

- [ ] Sleep
- [ ] Relationships
- [ ] Work performance
- [ ] School performance
- [ ] Other:

36) Thinking about different aspects of your life—your work, your health, what goes on at home, how you spend free time—how satisfied are you with your quality of life within the last month?

▢ Extremely satisfied ▢ Satisfied ▢ Neither satisfied or dissatisfied

▢ Dissatisfied ▢ Extremely dissatisfied

37) Please describe the amount of stress you have been feeling.

▢ Never stressed ▢ Very little stress ▢ Some amount of stress ▢ Moderate amount of stress

▢ Great deal of stress

38) I look forward to the future with hope and enthusiasm:

▢ True ▢ False ▢ Neither ▢ Varies

39) Would you say your current physical health is:

▢ Excellent ▢ Very Good ▢ Good ▢ Fair ▢ Poor

40) Would you say your physical health throughout your life has been:

▢ Excellent ▢ Very Good ▢ Good ▢ Fair ▢ Poor

41) Present or past disabilities or serious illnesses? ▢ No ▢ Yes

Disability or Illness	Age	Disability or Illness	Age

42) Medical problems that required surgery or serious accidents? ▢ No ▢ Yes

Surgery or Accident	Age	Surgery or Accident	Age

43) Have you ever been arrested? ▢ No ▢ Yes

*If **Yes**, please explain:*

44) Do you own a weapon? ▢ No ▢ Yes

*If **Yes**, please explain:*

45) In general, how would you describe your ability to control your anger in the past and present:

▢ Very good ▢ Not well (smash, break objects)

▢ Okay (worry about it sometimes) ▢ Problematic (have hit people)

Please explain:

46) Has there ever been a period of time when you were not your usual self and…

…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? ▢ No ▢ Yes

…you were so irritable that you shouted at people or started fights and/or arguments?

▢ No ▢ Yes

…you got so much less sleep than usual and found you didn't really miss it? ▢ No ▢ Yes

…thoughts raced through your head or you couldn't slow your mind down? ▢ No ▢ Yes

…you were so easily distracted by things around you that you had trouble concentrating or staying on track? ▢ No ▢ Yes

…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ▢ No ▢ Yes

…spending money got you or your family in trouble? ▢ No ▢ Yes

*If **Yes** to any of these statements, please explain further:*

Please state in detail what your present difficulties are, how long they have existed, and your reasons for seeking treatment currently. Use as much space as you need.

Please describe as best you can what your goals are in treatment:

INCOME AND OTHER RESOURCES

We will set your weekly therapy fees based on a formula of: 1) your insurance coverage; 2) financial help from family members; and 3) your weekly income. Please call your insurance company and ask them to review the coverage for "outpatient psychotherapy" with an "out-of-network provider". To help set your clinic fees please fill out the following:

Net Income (Weekly): $ Your partner's/spouse's net income (Weekly): $

Other Income: $ Savings: $

Monthly rent: (if you share the rent, state your proportionate share): $

List the relationship and ages of those persons who are financially dependent on you:

Relationship	Age	Relationship	Age

Please list the type and amount of any unusual debts, expenses, and/or financial obligations you have:

How much financial support per week could you receive from family members for psychotherapy?

How much could you afford to spend out-of-pocket per week toward psychotherapy?

Do you have any of the following benefits:

- ▢ Privately paid health insurance
- ▢ Health insurance paid through your Employment
- ▢ Medicare
- ▢ V.A. Benefits
- ▢ SSD
- ▢ SSI
- ▢ Unemployment

If you have health insurance: Name of Plan Phone:

Is insurance contingent upon employment? ▢ No ▢ Yes

Does your insurance cover treatment only by in network providers? ▢ No ▢ Yes

If No, please answer the following questions about out-of-network benefits:

Deductible: $ Maximum number of sessions per year covered by insurance:

Maximum dollar limit of mental health per year covered by insurance: $

Maximum fee per session or % of fee covered by insurance: $

CONSENT FORM

I, _____, have consented to psychotherapy/psychoanalysis with a candidate, psychology postdoctoral fellow, psychiatry resident or social work/psychology intern/extern at the William Alanson White Institute. Many of our therapists have completed their graduate degrees and are licensed. Others are earning degrees or are completing licensing requirements. I understand that the Institute serves educational purposes and the professionals who render the services are required to participate in clinical supervision and classes with licensed and highly qualified professional supervisors approved by the Institute. I further understand that these educational experiences require reporting of clinical data, and I give my permission for this to occur under conditions that will maintain the utmost confidentiality.

THE INFORMATION TO BE DISCLOSED INCLUDES THE NATURE AND EXTENT OF MY PROBLEMS AND IS TO BE USED BY THE ABOVE AGENCY TO ASSESS MY NEEDS AND AID IN PLANNING MY TREATMENT.

Witness:_____

Patient Signature: _____ **DATE**_____

Therapist Signature: _____ **DATE**_____

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