Dear Applicant,

Thank you for contacting the TICP Referral Service. After completing the enclosed therapy application form, please mail it to the address listed below, or fax to 416.288.8060, or email to info@ticp.on.ca . We assure you that your application will receive careful consideration and will be held in the strictest of confidence. We will contact you promptly with the name of a therapist who is available to meet with you to assess your needs and provide the treatment you require. Our therapists are not covered by OHIP and therefore the fee for psychotherapy sessions is discussed and determined during your first treatment session. We hope it will be possible for us to help you. Should we be unable to provide the services you need, every effort will be made to connect you with other agencies or individuals who may be able to do so.

Thank you again for using our services.

Sincerely,

TICP Referral Service Committee

Toronto Institute for Contemporary Psychoanalysis

Therapy Application

Name:_____
First Initial Last

Date of Birth: ___/___/___ Date of Application: ___/___/___
D M Y D M Y

Home Address:_____

Business Address: _____

Home Tel:( ) _____ Business Tel:( ) _____

May we leave a telephone message for you at your home?: Yes / No

May we leave a telephone message for you at your business?: Yes / No

Preferred mailing address?: home / business.

Occupation: _____

By whom were you referred?

Name: _____
Address: _____
Phone number: ( ) _____

Do you require wheelchair access? Yes / No

Are you able to schedule sessions during regular work hours? Yes / No

If not, please state times that would be possible to schedule sessions:

_____

Type of treatment you are seeking:
___ Psychoanalysis (four times a week)
___ Psychotherapy (one to three times a week)
___ Unknown

Do you have any privately paid health insurance? Yes / No
If yes, please indicate whether it covers psychotherapy services. Yes / No
Maximum dollar amount covered per year: _____
Do you have preferences with regard to the therapist (e.g., age, gender, orientation)?
If so, please state, giving reasons:

Please check all the reasons you are seeking psychotherapy. You may check more than one, but please indicate the main reason by placing a 1 in the column next to the item.

____ Anxiety
____ Bereavement
____ Confusion about self-image, goals etc.
____ Decreased performance at work, home, or school
____ Depression
____ Health status of myself, or someone I care about
____ Memory problems
____ Relationship problems
____ Problems with alcohol or drug use
____ Planning the future
____ Concerns about sexual abuse
____ Concerns about physical abuse
____ Aftermath of a trauma
____ Concerns about anger management
____ Concerns about the amount of stress you are experiencing
____ Thoughts or attempts at suicide
____ Concerns about sexual performance or enjoyment
____ Other (Specify) _____

Have you been in psychotherapy previously?
No _____ Yes (two to four times) _____
Yes (once)_____ Yes (more than four times) _____

If yes, please state when you were last in therapy _____
What was the longest time in any one therapy? _____

Frequency of sessions per week for your longest therapy: _____

Have you ever been hospitalized for emotional or mental problems?: Yes/No
If yes, number of hospitalizations? _____
Date of most recent hospitalization? _____
Duration of most recent hospitalization _____

Please state as fully as you can what your present difficulties are, how long they have existed, and your reasons for seeking treatment at this time. (Use as much space as needed):