

**APPLICATION FOR COUPLES PSYCHOTHERAPY**

WCSPP provides psychotherapy to couples seeking to work on issues in their relationship. Our therapists are enrolled in our postgraduate training program and receive weekly supervision from senior faculty members. Fees are based on a sliding scale of $30- $55 to help those with financial limitations. A commitment of 40 weeks of weekly treatment is required. Patients are seen in private offices. We are not equipped to offer services to those in crisis or seeking short term counseling. If this is an emergency, we recommend that you contact your local hospital emergency center.

The application process takes approximately two weeks. Upon receipt of your application, we will contact each partner to briefly discuss the concerns over the phone. We will consider your application thoughtfully and determine whether we can place you with a therapist in our training program. If you have any questions, please feel free to contact WCSPP at 914-997-7500.

\*NOTE: **EACH PARTNER** IN THE COUPLE NEEDS TO PRINT OUT AND COMPLETE THIS APPLICATION. BOTH COPIES SHOULD BE MAILED TO THE ADDRESS LISTED AT THE END OF THIS APPLICATION.

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about WCSPP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list everyone who lives in your household (name, relationship to applicant, age):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of person with whom you are seeking couples therapy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing an individual therapist? Yes No If yes, since when and with whom?

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Previous experience with outpatient individual therapy? Yes No If yes, when and with whom?

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Past experience with couples therapy? Yes No If yes, when and with whom?

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Have you ever been hospitalized for a psychiatric illness? Yes No If yes, when, where and why?

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Have you ever had suicidal thoughts? Yes No If yes, please describe:

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Have you ever made a suicide attempt? Yes No If yes, please specify number of attempts, when and how:

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Are you currently abusing alcohol or substances? Yes No If yes, please describe:

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Do you have a history of alcohol or substance abuse?: Yes No If yes, please describe:

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Do you have ongoing and/or current medical problems: Yes No If yes, please describe:

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Are you currently taking any medication, including psychiatric medication? Yes No If yes, please list and describe:

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We will set your fee based on a sliding scale of your income, including family/partner income.

What is your weekly income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family weekly income?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What days and times are possible for you and your partner to schedule appointments?

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Please describe your reason for seeking couples therapy at this time. Describe your concerns, how long they have lasted and how you hope therapy will help you. (Feel free to use as much space as you need).

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have consented to couples therapy with a candidate. WCSPP candidates are masters or doctoral level clinicians enrolled in our postgraduate training programs. I understand that WCSPP provides education and training to candidates which involves clinical consultation or supervision with WCSPP faculty and other qualified mental health professionals regarding the services they provide. ***I further understand that WCSPP does not permit the use of health insurance plans.\**** WCSPP is committed to maintain the utmost confidentiality.

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Signature Date

Please mail or fax completed application to:

WCSPP Attn: Administrator

1889 Palmer Avenue, Suite 6, Larchmont, NY 10538

T: 914-997-7500 F: 914-997-7501

E: info@wcspp.org W: [www.wcspp.org](http://www.wcspp.org)