JOSHUA NELSON, PH.D.
71 WEST 23RD STREET
SUITE 1115
NEW YORK, NY 10010

PERSONAL INFORMATION
NAME_____
ADDRESS_____
CITY, STATE, ZIP_____
HOME PHONE_____CELL_____
EMAIL_____
SOCIAL SECURITY NUMBER_____
DATE OF BIRTH_____AGE_____PLACE OF BIRTH_____

EDUCATION
HIGH SCHOOL_____ CURRENT YEAR OR GRADUATION YEAR_____
COLLEGE_____CURRENT YEAR OR GRADUATION YEAR_____
GRADUATE SCHOOL_____ CURRENT YEAR OR GRADUATION YEAR_____

EMPLOYMENT
OCCUPATION_____EMPLOYER_____

SIBLINGS (INCLUDING STEP-SIBLINGS AND HALF-SIBLINGS)
_____AGE_____ _____AGE_____
_____AGE_____ _____AGE_____
_____AGE_____ _____AGE_____

CURRENT RELATIONSHIP STATUS
_____SINGLE _____MARRIED _____SEPARATED _____DIVORCED _____WIDOWED
_____DOMESTIC PARTNER
LENGTH OF CURRENT RELATIONSHIP (if applicable)_____
CURRENT PARTNER'S NAME_____

PAST SIGNIFICANT ROMANTIC RELATIONSHIPS (INCLUDING AGE DURING RELATIONSHIP, LENGTH OF RELATIONSHIP, AND PARTNER'S NAME)_____
_____
_____

CHILDREN (INCLUDING STEPCHILDREN)
_____AGE_____ _____AGE_____
_____AGE_____ _____AGE_____
_____AGE_____ _____AGE_____

IF CLIENT IS A CHILD OR TEENAGER, HE/SHE LIVES WITH
___BOTH PARENTS ___MOTHER ___FATHER

IF PARENTS ARE DIVORCED, NATURE OF CUSTODY AGREEMENT_____
_____

IF CLIENT IS A CHILD OR TEENAGER (addresses only necessary if different than above)
FATHER'S NAME _____MOTHER'S NAME_____
ADDRESS_____ADDRESS_____
CITY, STATE, ZIP_____CITY, STATE, ZIP_____
PHONE_____ PHONE_____
OCCUPATION_____OCCUPATION_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP TO CLIENT_____
TELEPHONE_____ADDRESS_____

HEALTH HISTORY
CURRENT SIGNIFICANT HEALTH PROBLEMS AND MEDICATIONS_____
_____

PSYCHOTHERAPY AND PSYCHIATRIC HISTORY (if applicable)
PAST PSYCHOTHERAPY (INCLUDING AGE DURING AND LENGTH OF TREATMENT)_____
_____
PSYCHIATRIC MEDICATIONS (past and present)_____
_____

FAMILY PSYCHIATRIC HISTORY _____
_____
_____

PRIMARY PHYSICIAN
NAME OF DOCTOR_____
ADDRESS_____PHONE_____
I authorize the release of confidential information regarding my treatment or my child's treatment by Joshua Nelson, Ph.D. to my own or my child's primary physician for the purpose of coordinating care. YES_____ NO_____

PSYCHIATRIST (if applicable)
NAME OF DOCTOR_____
ADDRESS_____PHONE_____
I authorize the release of confidential information regarding my treatment or my child's treatment by Joshua Nelson, Ph.D. to my own or my child's psychiatrist for the purpose of coordinating care. YES_____ NO_____

SCHOOL OFFICIALS (for children and teenagers)
NAME OF SCHOOL_____
IMPORTANT CONTACT PEOPLE_____
ADDRESS_____PHONE_____
I authorize the release of confidential information regarding my child's treatment by Joshua Nelson, Ph.D. to the above mentioned school officials for the purpose of coordinating care. YES_____ NO_____

SESSION SCHEDULING
In order for therapy to be most beneficial, we will meet on at least a once-per-week basis. Occasional re-schedulings and cancellations, if necessary, must be made at least two business days in advance. All appointments cancelled within two business days, for any reason, cannot be rescheduled and will be fully charged. The office is closed on all Federal Holidays and when I am on vacation. During occasional vacations, when I am not reachable, another psychologist will be covering for me.

PAYMENT AND RECEIPTS
Please bring payment to each session. I accept checks and cash, but not credit cards. I will give you a receipt at the end of the month that can be used for out-of-network insurance reimbursement. I am not on any insurance panels at this time.

PHONE AND ONLINE VIDEO SESSIONS
Occasionally, phone or online video sessions can be conducted rather than in-person meetings. All policies regarding scheduling and fees apply equally to these as to in-person meetings. Please bring payment to the following meeting. Privacy issues, especially for online video sessions, will be discussed prior to the first session.

OUT OF SESSION CONTACTS
For scheduling issues, I can be reached by either phone or email, and I will respond by the same method. For all clinical issues, please contact me by phone and, if I am unable to answer, leave a message. I will call you back as soon as possible.

TREATMENT AGREEMENT
I hereby formally consent to entering into a treatment relationship with Joshua Nelson, Ph.D. I have read and agree to all statements listed in this agreement, including those regarding scheduling and fees. I acknowledge and accept the potential privacy limitations inherent in email and online communications. I understand that psychotherapy is voluntary and that I may stop treatment at any time. I also understand that, except under certain circumstances that are defined by New York State law, all treatment is confidential.

X_____
SIGNATURE OF CLIENT OR PARENT OF MINOR CLIENT **DATE**