JULIA M. KIM, PHD
HOSPITAL FOR SPECIAL SURGERY
535 EAST 70TH STREET
NEW YORK, NY 10021

Date: _____

Full Name: _____

Address (street, city, zip): _____

Home Telephone: _____ Cell Phone: _____

Work Telephone: _____ Email: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Job Title/Employer: _____

Person to Contact in Emergency: _____

Relationship: _____ Telephone: _____

Referring Physician: _____

Reason for Referral: _____

_____

_____

Medical/Surgical History: _____

_____

_____

_____

Medications (including aspirin, over-the-counter, birth control pills, vitamins, herbal preparations):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently in, or have you ever been in psychotherapy before: _____

If yes, was it helpful? Explain: _____

_____

_____

_____ _____

Patient Signature Date