

New Member Application Form

| | |
|------------------------------|-----------------------|
| Name: _____ | License Number: _____ |
| Degrees: _____ | Licenses: _____ |
| Address: _____ | |
| City/State/Zip: _____ | |
| Phone: _____ | Email: _____ |
| 2nd Office Address: _____ | |
| City/State/Zip _____ | |
| 2 nd Phone: _____ | |

| | | | |
|-------------------------|--|---|--------------------------------------|
| E/D Populations and Age | <input type="checkbox"/> Anorexics | <input type="checkbox"/> Women | <input type="checkbox"/> Individuals |
| | <input type="checkbox"/> Bulimics | <input type="checkbox"/> Men | <input type="checkbox"/> Couples |
| Modalities Served: | <input type="checkbox"/> Overeater | <input type="checkbox"/> Children | <input type="checkbox"/> Families |
| | <input type="checkbox"/> Overweight | <input type="checkbox"/> Adolescents | <input type="checkbox"/> Groups |
| | <input type="checkbox"/> Other ED | <input type="checkbox"/> Adults | <input type="checkbox"/> Inpatients |
| | | <input type="checkbox"/> Outpatients | |
| | <input type="checkbox"/> General Population | <input type="checkbox"/> Depression | |
| | <input type="checkbox"/> Addictions | <input type="checkbox"/> Schizophrenia | |
| | <input type="checkbox"/> Affective Disorders | <input type="checkbox"/> Dissociative Disorders | |
| | <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Other | |

| | | | |
|-----------------------------|--------------------------------|--------------------------------|--------------------------------|
| Other Clinical Specialties: | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

| | | |
|---------------------|---|--|
| Treatment Approach: | <input type="checkbox"/> Educational | <input type="checkbox"/> Art Therapy |
| | <input type="checkbox"/> Cognitive behavioral | <input type="checkbox"/> Dance/ Movement Therapy |
| | <input type="checkbox"/> Psychodynamic | <input type="checkbox"/> Body Work / Massage |
| | <input type="checkbox"/> Family Systems | <input type="checkbox"/> Medical / Physical complaints |
| | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Medical / Psychopharmacological |
| | <input type="checkbox"/> Psychoanalytic | <input type="checkbox"/> Nutritional |
| | <input type="checkbox"/> Eclectic / Integrative | |

| | | |
|--------------------------|--|--|
| Professional Background: | <input type="checkbox"/> Art Therapist | <input type="checkbox"/> Nutritionist |
| | <input type="checkbox"/> Dance & Movement Therapist | <input type="checkbox"/> Pediatrician |
| | <input type="checkbox"/> Dentist | <input type="checkbox"/> Physician |
| | <input type="checkbox"/> Internist | <input type="checkbox"/> Psychiatrist |
| | <input type="checkbox"/> Gynecologist | <input type="checkbox"/> Psychologist |
| | <input type="checkbox"/> Marriage & Family Counselor | <input type="checkbox"/> Social Worker |

Training: _____

Current Positions: _____

Prof. Experience: _____

Ins. Coverage: _____

Please complete and send with fee to:
APTED

3195 California Street, San Francisco, CA 94115