Strides in Psychotherapy

(732) 873-5570

15 Clyde Road, Suite 102
Somerset, NJ 08873

31 Dehart Place, Suite 2
Morristown, NJ 07960

Tammy Dorff, Psy.D. NJ Lic#3950

Linda Tamm, Psy.D NJ Lic #3926

INTAKE FORM – ADULT VERSION

Identifying Data

Date: ______________________

Name:____DOB:_________________________
Address:____
____
Phone #: home___________________________________Cell:___________________________________
Email: ____ Social Security #:_________________________
Occupation: ______________________________________ Work #: _________________________________

Emergency Contacts

Name:____Relationship to you:___________________________
Address:____
____
Phone #: home_________________________________Work:_____________________________________
Cell: __________________________________ Email: ____

Additional Information

How were you referred to us:____
Any current or potential legal involvement in your situation?______ if yes, what are the names of the law firms involved?____
____
What goals/issues/concerns have resulted in your seeking therapy at this time?
____
____
____
What do you hope to gain from therapy: ____
____
____

Household members, age, and their relationship to you:
____
____
____
Other very important people in your life – name and relationship to you:
____
____
____
What are your relationships with your family like? ____
____

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____
____

Please describe any current or recent stressors you have been dealing with:
____
____
____

Medical/Psychiatric/Substance Abuse History:

Medical Doctors Name & Phone #: ____
Psychiatrist's Name and Phone #: ____
Current Medical Problems: ____
____
____
Medications you are taking (including psych/medical meds): ____________________________
____
____
Medication Allergies:____
____
Please list any significant past medical problems, injuries, surgeries, or medical hospitalizations you had with dates: ____
____
Any previous history, if any, of psychotherapy (i.e., school, or religious counselor, individual or family counseling, patrial hospitalization program, inpatient treatment? __________________________
____
____
Please list the names/phone #'s, locations of any previous treaters, as best as you can recall:
____
____
____
____
How much alcohol do you drink and how often: ___________________________________
What drugs (i.e., marijuana, cocaine, heroin, acid, ecstasy, inhalants, etc.), if any, so you use, how much and how often: ____
____
Any history of abusing prescription medications or over the counter medications? If yes, please describe:
____
____
Please list any history of substance abuse treatment (outpatient or impatient detox, rehab, 12-step programs etc.): ____
____
Have you ever made any suicide attempts or suicidal gestures (if so, describe the attempt(s), date(s) and any medical/psychiatric treatment received afterwards): ______________________________
____
____

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Have you ever intentionally injured yourself but without suicidal intent—i.e., cutting, burning, or scratching yourself, head banging, etc.? (If so, please describe what happened, when, and any treatment received): ____

____

Have you ever experienced any sexual, physical, or emotional abuse or neglect? (If yes, please describe to the extent that you feel comfortable doing so): ______________________________

____

____

Have you ever physically harmed or threatened to harm anyone? - if yes, please give details, dates and any repercussions from this:______________________________

____

Have you ever done any property damage (i.e., punched holes in walls, broken furniture, thrown things, and broken them, kicked down doors, etc.)—if yes, please give details: ______________

____

____

Please list any current/past legal problems (including history of arrests, jail, detention, DWI's, restraining orders) with approximate dates: ______________________________

____

Please check all that apply to you or are issues for you now or have been in the past:

_____sleep problems	_____ appetite problem	_____ memory problems
_____ concentration difficulties	_____ short attention span	_____ impulsive behavior
_____ shoplifting	_____ spending sprees	_____ speeding
_____ unsafe sex	_____ promiscuous sex	_____ prostitution
_____ physical disability	_____ developmental disability	_____ fire-setting
_____ anorexia	_____ bulimia	_____ overeating
_____ suicidal ideation	_____ suicide attempts	_____ domestic violence
_____ victim of physical abuse	_____ alcohol problem	_____ drug problem
_____ victim of rape/sexual abuse	_____ seeing things others do not	_____ perpetrator of sexual/physical abuse
_____ hearing things that others do not	_____ anger issues	_____ severe loss/grief

_____ fears that others are trying to harm me/are following me/saying bad things about me

_____ recent weight change (describe): ______________________________

_____ vision difficulty (describe): ______________________________

_____ hearing difficulty (describe): ______________________________

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Family History:

Please check below if anyone in your immediate or extended family has experienced the following:

____ Developmental disability ____
____ Physical disability ____
____ Depression ____
____ Bipolar Disorder/Manic Depression ____
____ Anxiety ____
____ Psychosis/Schizophrenia ____
____ Suicide attempts ____
____ Completed suicide ____
____ Alcohol addiction ____
____ Drug addiction ____
____ Learning difficulties ____
____ Attention problems ____
____ Attention deficit disorder ____
____ Physical Abuse ____
____ Sexual Abuse ____
____ Eating disorders ____

Other Pertinent Information:

Religious Affiliation?: ____

What role, if any, does religion or spirituality play in your life? ________________________________
____

Activities/Interests/Groups: ____
____
____
____

What are your strengths? ____
____
____

Please add any other information you feel is important for me to know: ___________________________
____
____
____
____
____
____
____
____
____

Thank you!