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 – CHILD/ADOLESCENT VERSION

Date: _____

Childs Name:_____Childs DOB:_____

Age:_____ Social Security #: _____

How were you referred to me? : _____

Any Current or potential legal involvement in your situation? _____ if yes what are the names of the law firms involved: _____

Parents/Guardians:

Name:_____

Address:_____

_____

DOB:_____Social Security #:_____

Phone # (H):_____work #_____

Cell #: _____Email:_____

Occupation: _____ Relationship to child _____

Name:_____

Address:_____

_____

DOB:_____Social Security #:_____

Phone # (H):_____work #_____

Cell #: _____Email:_____

Occupation: _____ Relationship to child _____

Who has (singular or joint) legal custody of this child? :_____

Other emergency contacts or primary caretakers (stepparents, grandparents, partners, etc.)

Name:_____

Address:_____

_____

Phone # (H):_____work #_____

Cell #: _____Email:_____

Relationship to child _____

School information:

Name of school: _____Grade in school: _____

School Address: _____

School Phone #: _____ Current Teacher: _____

School Counselor Name & Phone # (if relevant): _____

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Is your child classified ☐ No ☐ Yes – Classification/Diagnosis: _____
Child Study Team Case Manager Name & Phone #: _____

Please list household members names, ages, and relationships to the child:

_____
_____

Please list any other important people in your child's life and their relationship to them:

_____
_____

Presenting Problems:

Why are you bringing you child to treatment at this time? What are the main concerns?

_____
_____
_____
_____

Recent stressors in the family – please check all that apply:

- ☐ Change of residence
- ☐ Change in caregivers' employment
- ☐ Loss of job for parent/guardian
- ☐ Money problems
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Gender identity/sexual orientation dev.
- ☐ New School/change in school for child
- ☐ Family member or close friend moved away
- ☐ Child has seen others get hurt, beaten up or killed
- ☐ Birth of family member
- ☐ Friend died or tried to kill self
- ☐ DYFS involvement with family
- ☐ Sibling leaves home
- ☐ Family members mental illness
- ☐ Children not getting along together
- ☐ Physical illness in family member
- ☐ Close family member in jail/prison
- ☐ Homeless/ no long-term home
- ☐ Legal problems
- ☐ Couple/marital problems
- ☐ Marital affair
- ☐ Separation
- ☐ Divorce
- ☐ Remarriage
- ☐ Adjusting to stepsiblings
- ☐ Domestic Violence
- ☐ Child recently hospitalized
- ☐ Death of family member
- ☐ Sexual abuse/rape of family member
- ☐ Wedding in the family
- ☐ Other _____

Describe any ***stressors*** that may currently be affecting your child:

_____
_____

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Does your child have any history of ***suicidality or self-injurious behavior*** (i.e., cutting self, burning self, starving self, binging, and purging)? If yes, please describe: _____

_____

_____

Does your child have any history of ***harming anyone else physicall***y or of ***destroying things*** (i.e., punching holes in walls, breaking down a door, fire-setting): _____

_____

Has your child ever had any **legal problems** (i.e., arrests, juvenile detention, etc.)? If yes, please describe:

_____

Does your child have any history of using or abusing **tobacco, alcohol, or drugs**? If yes, please describe and list any history of treatment for this problem: _____

_____

Does your child have any history of being **sexually or physically abused or neglected**? If yes, please describe: _____

_____

Prenatal/Neonatal Developmental History

Were there any complications during pregnancy or delivery? _____

Were there any delays in reaching developmental milestones (i.e., sitting, crawling, walking, feeding self, speech, talking, toilet training etc.) or other early concerns about your child? :_____

If yes, please describe:_____

_____

Childs Psychiatric Treatment History:

What previous history, if any, has your child experienced with psychotherapy (i.e., seeing a school counselor, individual or family counselor, partial hospitalization program or inpatient treatment)? :

_____

_____

Please list the names/phone #'s, locations of any previous treaters, as best as you can recall:

_____

_____

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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 _____

Names of therapists for other family members: _____
_____
_____

Medical History:

Child's Physicians Name: _____
Physicians Phone #: _____
Child's Psychiatrists Name (if applicable): _____
Psychiatrists Phone #: _____

Childs current and past Medical Problems: _____
_____
_____

List all of the child's current psych and medical medications (with dosages, RX M.D., for what illness/problem: _____
_____

Child's Medication Allergies:_____
_____
Other allergies: _____
_____

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Please list any significant past medical problems, injuries, surgeries, or medical hospitalizations your child had with dates:

_____

_____

Other Pertinent Information:

Languages spoken at home: _____

Religious Affiliation? :_____

Is your child adopted? ____No ____Yes, if so, what age: _____

Is anyone else in the family adopted? ____ No ____ Yes, if so, who? _____

Is your child or family currently involved with DYFS? ? ____ No ____ Yes , if so – Name & Phone # of Case worker: _____

What are your Child's strengths?

_____

_____

_____

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

_____

_____

_____

_____

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