15 Clyde Road, Suite
102 Somerset, NJ 08873
P: (732) 873-5570

Strides in Psychotherapy, P.C.™

31 Dehart Street, Suite 2
Morristown, NJ 07960
C: (732) 507-2417

Intake Form for Adults

Identifying Data Date: _____

Name:_____DOB:_____Age:_____
Address:_____
_____
Cell #: _____ Home #:_____
Email: _____
Occupation: _____ Work #: _____
Gender Identity:_____ Race/Ethnicity:_____

Emergency Contact

Name:_____Relationship to you:_____
Address:_____
_____
Cell # _____ Home #:_____
Work #: _____ 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, ages, and their relationship to you: _____
_____
_____
_____
Other very important people in your life – names and relationship to you:
_____
_____
_____
What are your relationships with your family like? _____
_____
_____
_____

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

Linda Tamm, Psy.D., Owner
NJ Lic #3926

Tammy Dorff, Psy.D., Owner
NJ Lic#3950

Last updated 9/4/2024

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Medical/Psychiatric/Substance Abuse History:

Medical Doctor's Name & Phone #: _____
Psychiatrist's Name and Phone #: _____
Current Medical Problems: _____
_____
_____
Medications you are taking (including psychiatric/medical medications):
_____
_____
Medication Allergies:_____
_____
Please list any significant past medical problems, injuries, surgeries, or medical hospitalizations you have had with dates: _____
_____
Any previous history, if any, of psychotherapy (i.e., school, or religious counselor, individual or family counseling, partial hospitalization program, inpatient treatment? _____
_____
_____
Please list the names and phone #'s of any previous treaters: _____
_____
_____
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 vaping or cigarette smoking? If yes, please describe:_____
_____
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: _____
_____
_____
Have you ever intentionally injured yourself without suicidal intent—i.e., cutting, burning, or scratching yourself, head banging, etc.? If yes, 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: _____
_____
_____

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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
- ☐ memory problems
- ☐ concentration difficulties
- ☐ short attention span/ADHD
- ☐ impulsive behavior
- ☐ shoplifting
- ☐ spending sprees
- ☐ speeding
- ☐ unsafe sex
- ☐ promiscuous sex
- ☐ prostitution
- ☐ appetite problem
- ☐ anorexia
- ☐ bulimia
- ☐ overeating
- ☐ recent weight change (describe): _____
- ☐ fears that others are trying to harm me/are following me/saying bad things about me
- ☐ vision difficulty (describe): _____
- ☐ hearing difficulty (describe): _____
- ☐ suicidal ideation
- ☐ suicide attempts
- ☐ severe loss/grief
- ☐ domestic violence
- ☐ victim of physical abuse
- ☐ victim of rape/sexual abuse
- ☐ perpetrator of sexual/physical abuse
- ☐ alcohol problem
- ☐ drug problem
- ☐ anger issues
- ☐ seeing things others do not
- ☐ hearing things that others do not
- ☐ fire-setting
- ☐ developmental disability/Autism
- ☐ physical disability

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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/Autism _____
- ☐ Depression _____
- ☐ Bipolar Disorder/ _____
- ☐ Anxiety/Panic Attacks _____
- ☐ Psychosis/Schizophrenia _____
- ☐ Suicide attempts _____
- ☐ Completed suicide _____
- ☐ Alcohol addiction _____
- ☐ Drug addiction _____
- ☐ Learning difficulties _____
- ☐ Attention problems/ADHA _____
- ☐ 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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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