Strides in Psychotherapy
732-873-5570

15 Clyde Rd. Suite 102
Somerset, NJ 08873

66 Maple Avenue
Morristown, NJ 07960

Tammy Dorff, Psy.D.
NJ Lic#3950

Linda Tamm, Psy.D
NJ Lic #3926

INTAKE FORM—ADULT VERSION

Identifying Data

Name: _____DOB:_____
Address: _____
_____
Phone #: home:_____ work:_____ cell:_____
Email #:_____Social Security Number: _____
Occupation: _____

Emergency contacts:

Name: _____ Relationship to you:_____
Address: _____
_____
Phone #'s:(H)_____(W)_____
Cell phone: _____ Email: _____

How were you referred? _____

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:
_____
_____
_____

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Other very important people in your life—name and relationship to you:_____
_____
_____

What are your relationships with your family like? _____
_____
_____
_____
_____

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

Medical/Psychiatric/Substance Abuse History:

Medical Doctor's Name and Phone #: _____
Psychiatrist's Name and Phone # (if applicable):_____
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 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 name/phone#/location of any previous treaters, as best as you can recall:

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How much alcohol do you drink and how often?_____
What drugs (i.e., marijuana, cocaine, heroin, acid, ecstasy, inhalants, etc), if any, do 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 tx, inpt 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 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: _____

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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 problem ___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 ___perpetrator of sexual/physical abuse
___hearing things that others do not ___seeing things that others do not
___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): _____

Family History:

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

Relatives:

___Developmental Disability _____
___Physical Disability _____
___Depression _____
___Bipolar Disorder/Manic Depression _____
___Anxiety _____
___Psychosis/Schizophrenia _____
___Psychiatric Hospitalization _____
___Suicide attempts _____
___Completed suicide _____
___Alcohol addiction _____
___Drug addiction _____

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___Learning difficulties _____
___Attention problems _____
___Attention deficit disorder _____
___Physical abuse _____
___Sexual abuse _____
___Eating disorders _____

<u>Other Pertinent Information</u>:

ReligiousAffiliation?_____
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 on the back of this page.

Thank you!