Psychotherapy Services, LLC
Dr. Susan Orshan
150 Morristown Road, Suite 215
Bernardsville, NJ 07924

INTAKE FORM

Date:_____

_____

Name (Age) (Date of Birth)

_____

Address
(Street, #, Apt., County, State and Zip)

_____

Email Marital Status Phone Number

_____

Occupation Work Phone Number

_____

Name of Insured Date of Birth of Insured

_____

Notify in Emergency Relationship

_____

Address Home Phone Number Work Phone Number

_____

Referred By Address Phone Number

Do I have your permission to contact referral source to thank this individual for referring you? _____yes _____no

INTAKE FORM (continued)

Chief Complaint: _____

_____

_____

_____

Previous
Hospitalizations:_____

_____

_____

Current Medical and Psychiatric Treatment:_____

_____

_____

Current Medications:_____

_____

_____

Significant Family History: (include medical, psychiatric, substance abuse and alcohol abuse)

_____

_____

_____

Signature: _____

Today's Date: _____