



**Therapeutic Alliance Group, Inc.**  
10 Forest Avenue, Suite 209 ♦ Paramus, NJ 07652  
Phone / Fax: 888-777-9691 Website: www.Talliancegroup.org

**Intake Form (Page 1 of 2)**

**We are excited you have chosen Therapeutic Alliance Group and look forward to your visit!  
Please print this form and bring it with you on your first visit.**

**Name:** \_\_\_\_\_ **Date of Visit:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone # (please circle preferred way to reach you):**

**C:** \_\_\_\_\_ **H:** \_\_\_\_\_ **W:** \_\_\_\_\_

**Referred from:** \_\_\_\_\_

**Insurance Information:**

**DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Carrier Name:** \_\_\_\_\_

**Carrier Phone # (usually on back of card):** \_\_\_\_\_

**ID#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Plan benefits: Deductible** \_\_\_\_\_ **Out of pocket maximum:** \_\_\_\_\_

**Co-insurance amount:** \_\_\_\_\_

**Requested services (please circle):**

- Individual
- Group Counseling
- Supervisory
- Presentations and/or ongoing trainings (Topic: \_\_\_\_\_)

**Reason(s) for visit:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other practitioners involved in your care (if applicable):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other related information:**



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**Intake Form (Page 2 of 2)**

**Personal Information:**

Identified Goals:	
Current Supports	
Counseling History	

**Medical Information (as applicable)**

Health status: (identified illness, etc)	
Accidents / surgeries	