ERIKA BISCHOFF, LCSW

CBT Therapist

COUPLES THERAPY
INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form before your first session.

Referral Source: _____

Client Name: _____ **Date of Birth:** _____

Partner Name: _____ **Date of Birth:** _____

Address of Primary Residence:

_____

_____

Home Phone: (___) ___-____
May I leave a message? ☐ Yes ☐ No

Cell Phone: (___) ___-____
May I leave a message? ☐ Yes ☐ No

Email: _____
May I email you? ☐ Yes ☐ No

Spouse/Partner's Address (if different):

_____

_____

Home Phone: (___) ___-____
May I leave a message? ☐ Yes ☐ No

Cell Phone: (___) ___-____
May I leave a message? ☐ Yes ☐ No

Email: _____
May I email you? ☐ Yes ☐ No

Please list names and ages of other family members living in the home(s):

_____

_____

_____

_____

General Relationship History

When long have you and your spouse/partner been together? _____

If married, how many years? _____ If separated, for how long? _____

How did you and your spouse/partner meet? _____

_____

What are the strengths in your relationship? _____

_____

How would you and your partner/spouse describe your relationship? _____

_____

Reason for seeking couples therapy at this time

Please include the following information:

1. What is the presenting issue/problem that is bringing you into therapy?

2. How long has this problem/issue has been occurring?

3. How is your relationship issue currently impacting each of your individual functioning?

4. What attempts have you made to address the problem/issue prior to seeking therapy?

5. How do you and your spouse/partner hope therapy will help your relationship?

Employment / Education Information

Occupation: _____ Level of Education: _____

Are you experiencing any current stress or difficulties in your job? ☐ Yes ☐ No If yes, describe.

Spouse/Partner
Occupation: _____ Level of Education: _____

Are you experiencing any current stress or difficulties in their job? ☐ Yes ☐ No If yes, describe.

Family Mental Health Background

Please answer the following questions as related to both yourself and your spouse/partner's family background.

Have you or your spouse/partner received mental health services? ☐ Yes ☐ No

If yes, who received services?

Who provided these services?

When and for how long were services?

What issue(s) was the focus of treatment?

How would you describe the experience? (i.e., positive, helpful, not helpful)

Is a psychiatrist currently treating you or your spouse/partner? ☐ Yes ☐ No

If yes, please identify person, name of psychiatrist, and the type of medication.

Have you or your spouse/partner ever been hospitalized for mental health services? ☐ Yes ☐ No

If yes, please identify person, the date(s), reason(s), and location(s).

Family Medical Background

Have either of you ever been diagnosed with a serious medical condition? ☐ Yes ☐ No
If yes, please describe.

Are either of you currently experiencing any medical/physical symptoms that are related to a mental, emotional, or stress-related condition?
If yes, please describe.

Current or Past Family Stressors

Is there a history of mental health issues in your family? ☐ Yes ☐ No
If yes, please describe.

Is there a history of addiction in your family? ☐ Yes ☐ No
If yes, please describe.

Is there a history of abuse or violence in your family? ☐ Yes ☐ No
If yes, please describe.