Joseph T. Wilkinson, LICSW
3949 Old Post Rd
Charlestown, RI 02891 Phone: 401-862-7254| Email:
privacy@josephtwilkinsonLICSW.com http://www.josephtwilkinsonlicsw.com/

Couples Counseling Intake Form

Please complete this form prior to your first couplestherapy session. Each partnershould complete their own form. Your responses are confidential and will help guide our work together.

Section 1: Contact Information

Full Name: _____

Date of Birth: _____ Age: _____
Gender: _____

Phone Number: _____

Email Address: _____

Preferred ContactMethod (Phone/Email/Text): _____

Occupation: _____

Emergency Contact(Name & Relationship): _____

Emergency ContactPhone Number: _____

Section 2: Relationship History

Partner's Full Name: _____

Length of Relationship: _____

Marital Status (circle one): Dating / Living Together / Married / Separated / Other

Children together or from previous relationships? If yes, please list names and ages:

_____

Briefly describe how you met and your relationship history:

_____

Section 3: Current Concerns

What concerns bring you to couplestherapy at this time?

_____

How do these issues impact your relationship?

_____

What have you already tried to address these concerns?

_____

Have either of you been in couplestherapy before? If yes, when and what was the outcome?

_____

Section 4: Individual History

Do you have any history of individual therapy or counseling? _____

Any significant medical or mental health diagnoses? If yes, please describe: _____

Do you use substances (alcohol, cannabis, etc.)? If yes, describe frequency and amount:

_____

Section 5: Goals for Therapy

What are your hopes or goals for therapy?

_____

What would success in couplestherapy look like to you?

_____

Section 6: Additional Information

Is there anything else you would like me to know before we begin? _____

Client Signature: ____________________________ Date: _______________