Susan Thau, Ph. D.
Certified EFT therapist and supervisor (PSY7317)
456 North Orange Drive Los Angeles, CA 90036
susanthau@gmail.com | (310) 829-5656

Intake Form

Dear New Patients,

If you are seeing me individually, please complete the following form. If you are seeing me for EFT couples therapy, I would like this form completed separately by each of you.

Please set aside 30 minutes to an hour to complete the form. When you have completed the form, you can mail it to the address above or scan it as an attachment and email it back to me.

Any details provided will be held in strictest confidence and not be disclosed or shared with anyone else. This will provide me with background information that will be helpful in our work together.

Thank you so much,
Susan Thau, Ph. D.

Your Full Name: _____

Current Relationship

Current relationship status
- ☐ Single
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Engaged
- ☐ Married
- ☐ Living with partner

If now married, how long? _____

Current spouse's name: _____

Did you live together before your current marriage?
- ☐ No
- ☐ Yes

If yes, how long? _____

If living with partner, for how long? _____

Partner's name: _____

Relationship History

Were you previously married or living with a partner?

☐ No
☐ Yes

Approximate dates of previous marriage or live-in partnership: _____

Children

Please include last name if different than yours

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Describe your relationship with your children: _____

_____

Referral Information and Previous Counselling

How did you come to contact Dr. Thau? _____

_____

Have you had therapy in the past?

☐ No
☐ Yes, Couple
☐ Yes, Individual

If yes, approximately for how long and when? _____

_____

Was it helpful?
☐ No
☐ Yes

Comments about past counseling: _____

_____

Current Concerns

Please rate the intensity of the distress you feel that led you to seek this therapy.
1 = Not intense, 2 = Moderately intense, 3 = Extremely intense *(circle your answer)*

_____
1 2 3

Approximately how long have you had the current issues/concerns? _____

Issues you would like to address at this time	How intense is this distress on a scale of 1-3 *(3 = high)*		
☐ Marital/couple stress	1	2	3
☐ Dating concerns	1	2	3
☐ Parenting	1	2	3
☐ Communication	1	2	3
☐ Career	1	2	3
☐ Finances	1	2	3
☐ Conflict resolution	1	2	3
☐ Extended family	1	2	3
☐ Addiction	1	2	3
☐ Infidelity	1	2	3
☐ Sexual concerns	1	2	3
☐ Fertility concerns	1	2	3
☐ Cross Cultural concerns	1	2	3
☐ Partner's anger	1	2	3
☐ Partner's withdrawal	1	2	3
☐ Anxiety	1	2	3
☐ Depression	1	2	3
☐ Self-esteem	1	2	3

Other issues not listed: _____

If you are seeking couples therapy, please answer the following questions:

At this point how motivated would you say you are to work on solving the problems in the relationship and finding a way to have a good relationship?

☐ Very motivated
☐ Not motivated
☐ Ambivalent
☐ Uncertain

Are you:

☐ Leaning in – interested in rebuilding the relationship
☐ Leaning out – unconvinced couples counseling can help
☐ Ambivalent
☐ Uncertain

Positives

List 8 things you are truly grateful for:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Education/Career

Highest level of education achievement: _____

Did you experience difficulties in school?

☐ None
☐ Little
☐ Some
☐ Substantial
☐ Constant struggle

Occupation: _____

Typical work schedule: _____

Are you satisfied in your work?
☐ No
☐ Yes

Why or why not? _____

Any financial issues that affect your current overall mood and wellbeing?
☐ No
☐ Yes

What are they? _____

Might work issues impact your therapy?
☐ No
☐ Yes

If so, what are they? _____

If you are seeking individual therapy, please answer the following questions:

Partner's occupation: _____

Spiritual/Religious Practices and History

Do you have a current religious affiliation?
☐ No
☐ Yes

Spiritual upbringing influences: _____

Are you satisfied with your spiritual life?
☐ No
☐ Yes

Comments: _____

Growing Up

Use 5 adjectives to describe, in general, how happy or adjusted you were growing up:

1. _____

2. _____

3. _____

4. _____

5. _____

How many siblings do you have? _____

Where are you in the birth order
- ☐ Youngest
- ☐ Middle
- ☐ Oldest

Other: _____

Describe your siblings and how you relate to them: _____

_____

_____

If you had a primary parent during childhood, use 5 adjectives or phrases to describe your relationship.

1. _____

2. _____

3. _____

4. _____

5. _____

If you had another parent during childhood, use 5 adjectives or phrases to describe your relationship.

1. _____

2. _____

3. _____

4. _____

5. _____

If you had more than one parenting figure please describe their relationship. Describe the relationship between your father and mother: _____

_____

_____

Parents' marital status
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Father remarried
- ☐ Mother remarried
- ☐ Other

Your Health

Do you exercise regularly?
- ☐ No
- ☐ Yes

Are you conscientious about your nutrition?
- ☐ No
- ☐ Yes

Do you have any current health problems?
- ☐ No
- ☐ Yes

If yes, please explain: _____

_____

Are you currently on any medication?

☐ No
☐ Yes

If yes, please list name(s) and reason for taking: _____

_____

Any past health problems?

☐ No
☐ Yes

If yes, please explain: _____

_____

Major surgeries?

☐ No
☐ Yes

If yes, please explain (include year): _____

_____

Has there been any alcohol and/or other drug abuse (past or present)?

☐ No
☐ Yes

If yes, please explain: _____

_____

Has there been any of sexual addiction/treatment?

☐ No
☐ Yes

If yes, please explain: _____

_____

Any suicide attempts?
☐ No
☐ Yes

If yes, when: _____

Family Health History
(blood relatives i.e. parents, siblings, grandparents, aunts, uncles, cousins, etc.)

If yes, please denote who by relationship not by name.

Depression
☐ No
☐ Yes
Who: _____
_____

Anxiety
☐ No
☐ Yes
Who: _____
_____

Attention deficit
☐ No
☐ Yes
Who: _____
_____

Suicide attempts/successes
☐ No
☐ Yes
Who: _____
_____

Alcohol and/or drug addiction or treatment
☐ No
☐ Yes
Who: _____
_____

Sexual addiction/treatment
☐ No
☐ Yes
Who: _____
_____

Significant illness (i.e., cancer, strokes)
☐ No
☐ Yes
Who: _____
What: _____

Other health situation
☐ No
☐ Yes

Who: _____

What: _____

Symptoms – Current and Past

Check all that apply to you. There is room below to comment further.

Always tired
☐ I have this now
☐ I used to have this

Sleep whenever I can
☐ I have this now
☐ I used to have this

Can't get going
☐ I have this now
☐ I used to have this

Lacking confidence
☐ I have this now
☐ I used to have this

Not enjoying usual activities
☐ I have this now
☐ I used to have this

Don't feel like being alone
☐ I have this now
☐ I used to have this

Feelings of guilt
☐ I have this now
☐ I used to have this

Depressed
☐ I have this now
☐ I used to have this

Losing weight
☐ I have this now
☐ I used to have this

Spiritually troubled
☐ I have this now
☐ I used to have this

Cannot make decisions
☐ I have this now
☐ I used to have this

Concerns about weight
☐ I have this now
☐ I used to have this

Nightmares
☐ I have this now
☐ I used to have this

Unusual fears
☐ I have this now
☐ I used to have this

Avoiding crowds
☐ I have this now
☐ I used to have this

Unable to relax
☐ I have this now
☐ I used to have this

Always worried
☐ I have this now
☐ I used to have this

Frequent sweating
☐ I have this now
☐ I used to have this

Muscles twitching
☐ I have this now
☐ I used to have this

Nausea, stomach problems
☐ I have this now
☐ I used to have this

Cannot stop doing certain repetitive behaviors
☐ I have this now
☐ I used to have this

Angry outbursts
☐ I have this now
☐ I used to have this

Cannot make friends
☐ I have this now
☐ I used to have this

Full of energy
☐ I have this now
☐ I used to have this

Excessive medication use
☐ I have this now
☐ I used to have this

Lacking in motivation
☐ I have this now
☐ I used to have this

Feeling worthless
☐ I have this now
☐ I used to have this

Feeling lonely
☐ I have this now
☐ I used to have this

Unresolved grief
☐ I have this now
☐ I used to have this

Headaches
☐ I have this now
☐ I used to have this

Frequent daydreaming
☐ I have this now
☐ I used to have this

Problems with parents or people who raised you
☐ I have this now
☐ I used to have this

Quick tempered
☐ I have this now
☐ I used to have this

Difficulties at work
☐ I have this now
☐ I used to have this

Lack of energy
☐ I have this now
☐ I used to have this

Trouble getting to sleep
☐ I have this now
☐ I used to have this

Tendency to put off doing things
☐ I have this now
☐ I used to have this

Feeling easily hurt
☐ I have this now
☐ I used to have this

Cannot concentrate
☐ I have this now
☐ I used to have this

Always hungry
☐ I have this now
☐ I used to have this

Thoughts of hurting myself
☐ I have this now
☐ I used to have this

Troubling sexual preoccupations
☐ I have this now
☐ I used to have this

Unusual thoughts
☐ I have this now
☐ I used to have this

Restless, tense
☐ I have this now
☐ I used to have this

Shaky hands
☐ I have this now
☐ I used to have this

Impatient with people
☐ I have this now
☐ I used to have this

Cannot handle money
☐ I have this now
☐ I used to have this

Marital/Couple problems
☐ I have this now
☐ I used to have this

Waking up during the night
☐ I have this now
☐ I used to have this

Excessive drinking
☐ I have this now
☐ I used to have this

Feeling inferior
☐ I have this now
☐ I used to have this

Loss of meaning to life
☐ I have this now
☐ I used to have this

Reliving past events
☐ I have this now
☐ I used to have this

Shy with people
☐ I have this now
☐ I used to have this

Racing thoughts
☐ I have this now
☐ I used to have this

Memory gaps
☐ I have this now
☐ I used to have this

Feel like hurting someone
☐ I have this now
☐ I used to have this

Unable to keep a job
☐ I have this now
☐ I used to have this

Loss of sexual interest
☐ I have this now
☐ I used to have this

Avoiding contact with friends
☐ I have this now
☐ I used to have this

Unable to have fun
☐ I have this now
☐ I used to have this

Crying spells
☐ I have this now
☐ I used to have this

Frequent thoughts of death
☐ I have this now
☐ I used to have this

Want to be alone always
☐ I have this now
☐ I used to have this

Poor appetite
☐ I have this now
☐ I used to have this

Feeling fearful
☐ I have this now
☐ I used to have this

Feeling panicky
☐ I have this now
☐ I used to have this

Numbness of tingling
☐ I have this now
☐ I used to have this

Poor health
☐ I have this now
☐ I used to have this

Feeling angry
☐ I have this now
☐ I used to have this

Financial problems
☐ I have this now
☐ I used to have this

Problems with children
☐ I have this now
☐ I used to have this

Worried about health
☐ I have this now
☐ I used to have this

Feel unloved/unforgiven by God
☐ I have this now
☐ I used to have this

Troubled by past events
☐ I have this now
☐ I used to have this

Gaining weight
☐ I have this now
☐ I used to have this

Quick to startle
☐ I have this now
☐ I used to have this

Fast heartbeat
☐ I have this now
☐ I used to have this

Dizzy, lightheaded
☐ I have this now
☐ I used to have this

Feeling irritable/on edge
☐ I have this now
☐ I used to have this

Difficulties with school
☐ I have this now
☐ I used to have this

Excessive drug use
☐ I have this now
☐ I used to have this

Sexual problems
☐ I have this now
☐ I used to have this

Feeling apathetic
☐ I have this now
☐ I used to have this

Comments on symptoms section, if needed: _____

_____

_____

Goals

List 3 goals you hope to realize through therapy:

1. _____

2. _____

3. _____

Additional comments you want to make about anything at all that you feel is relevant to our work together:

_____

_____

_____

_____

Today's Date (MM-DD-YYYY): _____

Looking forward to working with you.

Thank you