

COUPLES INTAKE PACKET

Each partner should complete his or her own Intake Form.

Both partners can sign the Office Policies form.

Please complete the 48 Hour Cancellation Policy.

Bring the completed packets with you to your first session.

The Buehler Institute

Stephanie Buehler, Psy.D., Director / PSY 17609
T 949-271-6330 / F 949-271-6331

Intake

Name _____

How would you like to be addressed? _____

Date of Birth: _____ Age: _____ Today's Date: _____

Address: _____

Primary phone: _____ Alternate phone: _____

Which number should be used for leaving messages? _____

How were you referred to The Institute? _____

Do we have permission to contact the person who referred you? ___ Yes ___ No

Who is your primary physician? _____

May we contact your primary physician for health information? Yes ___ No ___

Please answer the following questions. Your answers are confidential. If you are unsure how to answer or don't care to put something in writing, it is okay to "skip". Use the back of the page if needed.

1. What is the concern that has prompted you to seek assistance?

2. Have you sought help for this concern in the past? If so, what worked or did not work?

3. If you work outside the home, please describe your current job, e.g. type of work, position, number of years in current job. Also please describe anything unusual in job history, e.g. laid off recently, demoted.

4. Please circle: Single Domestic Partnership Married
 Divorced Remarried Number of marriages: _____

5. Do you have children? If so, how many and what are their ages?

6. Is there anything significant about your childhood, e.g. you lost a parent or sibling at a young age, lost home in a fire, parents divorced, parent alcoholic, etc.

7. Have you ever been emotionally, physically, or sexually abused? ___Yes ___No

8. Have you had a psychiatric hospitalization? If so, when, where, and for what reason, e.g. substance abuse rehabilitation.

9. Have you ever been under the care of a psychiatrist? If so, with whom, when, and for what reason?

10. Have you had psychotherapy in the past? If so, with whom, when, and for what reason?

11. Have you ever made a suicide attempt? Yes _____ Year _____ No _____

Has a relative ever made a suicide attempt or completed a suicide? Yes _____ No _____

Has any relative been diagnosed with a mental illness? If so, who and with what diagnosis?

12. Do you drink alcoholic beverages and/or use recreational drugs? Yes ___ No ___

If so, please list type of alcohol or drugs you use, how much, and how frequently, e.g. "Wine, 2 glasses, daily".

13. Have you ever had a head injury or concussion? Yes No

14. Do you experience any of the following? Please circle.

- | | | |
|----------------------|-------------------|------------------------|
| Feelings of sadness | Crying | Lack of energy |
| Keyed up, can't stop | Can't sleep | Overeating |
| Can't eat | Irritable | Worrying too much |
| Can't concentrate | Forgetful | Stressed |
| Feel empty | Injuring yourself | Nightmares, bad dreams |
| Spacing out | Binge eating | Sexual concerns |

16. What current interpersonal problems are you having, e.g. arguing with spouse or not getting along with your boss?

17. Do you have a spiritual practice or religion? If so, please your religion; whether you attend a church, temple or mosque regularly; or anything else important about your beliefs.

18. What is your country of origin? _____

19. Please list any medical problems and medications that you are currently taking.

To be completed by therapist:

Name of therapist: _____ Date of Intake: _____

The Buehler Institute
Stephanie Buehler, Psy.D., Director / PSY 17609
T 949-271-6330 / F 949-271-6331

Intake

Name _____

How would you like to be addressed? _____

Date of Birth: _____ Age: _____ Today's Date: _____

Address: _____

Primary phone: _____ Alternate phone: _____

Which number should be used for leaving messages? _____

How were you referred to The Institute? _____

Do we have permission to contact the person who referred you? ___ Yes ___ No

Who is your primary physician? _____

May we contact your primary physician for health information? Yes ___ No ___

Please answer the following questions. Your answers are confidential. If you are unsure how to answer or don't care to put something in writing, it is okay to "skip". Use the back of the page if needed.

1. What is the concern that has prompted you to seek assistance?

2. Have you sought help for this concern in the past? If so, what worked or did not work?

3. If you work outside the home, please describe your current job, e.g. type of work, position, number of years in current job. Also please describe anything unusual in job history, e.g. laid off recently, demoted.

4. Please circle: Single Domestic Partnership Married
 Divorced Remarried Number of marriages: _____

5. Do you have children? If so, how many and what are their ages?

6. Is there anything significant about your childhood, e.g. you lost a parent or sibling at a young age, lost home in a fire, parents divorced, parent alcoholic, etc.

8. Have you ever been emotionally, physically, or sexually abused? ___Yes ___No

8. Have you had a psychiatric hospitalization? If so, when, where, and for what reason, e.g. substance abuse rehabilitation.

9. Have you ever been under the care of a psychiatrist? If so, with whom, when, and for what reason?

10. Have you had psychotherapy in the past? If so, with whom, when, and for what reason?

11. Have you ever made a suicide attempt? Yes _____ Year _____ No _____

Has a relative ever made a suicide attempt or completed a suicide? Yes _____ No _____

Has any relative been diagnosed with a mental illness? If so, who and with what diagnosis?

12. Do you drink alcoholic beverages and/or use recreational drugs? Yes ___ No ___

If so, please list type of alcohol or drugs you use, how much, and how frequently, e.g. "Wine, 2 glasses, daily".

13. Have you ever had a head injury or concussion? Yes No

14. Do you experience any of the following? Please circle.

- | | | |
|----------------------|-------------------|------------------------|
| Feelings of sadness | Crying | Lack of energy |
| Keyed up, can't stop | Can't sleep | Overeating |
| Can't eat | Irritable | Worrying too much |
| Can't concentrate | Forgetful | Stressed |
| Feel empty | Injuring yourself | Nightmares, bad dreams |
| Spacing out | Binge eating | Sexual concerns |

16. What current interpersonal problems are you having, e.g. arguing with spouse or not getting along with your boss?

17. Do you have a spiritual practice or religion? If so, please your religion; whether you attend a church, temple or mosque regularly; or anything else important about your beliefs.

18. What is your country of origin? _____

19. Please list any medical problems and medications that you are currently taking.

To be completed by therapist:

Name of therapist: _____ Date of Intake: _____

STEPHANIE BUEHLER, M.P.W., PSY.D., CST.
California Licensed Psychologist 17609
THE BUEHLER INSTITUTE PSYCHOLOGICAL SERVICES, INC.
15615 Alton Parkway, Suite 450 / Irvine, CA 92618
3400 Central Avenue, Ste. 310 / Riverside, CA 92506
Phone & Fax: (800) 769-0342

1. Everything you say in psychotherapy is confidential with some exceptions. By law, I am required to report suspected child abuse or neglect and elder abuse and neglect. If I believe that you are a danger to yourself (suicidal), I am required to contact appropriate authorities to protect you. If I believe you are a danger to others (homicidal), I have a duty to warn others and to contact appropriate authorities to protect others.
2. Although I do not bill insurance, please be aware that in order for you to receive reimbursement I need to disclose information such as diagnosis, dates of services, or other needed information for your insurance company to process your claim.
3. I will end our session on time, meaning 50 minutes--not one hour. This allows me to make phone calls, write notes, and take a break. If you pay by check, please have your check prepared prior to session.
4. If you become in legal proceedings, neither you nor your attorney will request me to testify or disclose your psychotherapy records in order to protect your clinical file.
5. There is a 48-hour cancellation policy. (See attached.) With or without an appointment reminder from, you are responsible for coming to session. Missed appointments and late cancellations are charged my full fee and cannot be billed to insurance.
6. Scheduling. If possible, it is best to schedule for the same day and time each week. If not, I will work with you as best I can to accommodate your needs.
7. I do not carry a pager and can normally be reached only during regular business hours. If you have an emergency, please call 911 or have someone take you to an E.R.
8. I do not "friend" clients on social media sites.
9. Email is used only for scheduling purposes, and not to answer or exchange clinical information. Please note that any email exchange becomes part of your file.
10. If you have questions between sessions, call me, but be aware that I bill for calls longer than 10 minutes.
11. This is *your* therapy, so if you have questions or comments about my approach or your progress, speak up! Doing so may be an important clinical issue.
12. There is no contract between us. You may stop treatment at any time, for any reason. However, it is often advisable to attend a final session to assess the work that has been

accomplished, what might be addressed in the future, and so forth. Also, if you decide that you do not feel I am a good “fit” for you, I can provide you with referrals to other therapists.

13. Couples, please note: Since I am treating the “third party” in the room—the relationship--I do not keep secrets held by one or both partners because it compromises my ability to stay objective and can cause other clinical and legal problems. For the most part, I prefer to see couples together, but sometimes will schedule separate sessions to address important individual issues, e.g., past trauma. Also, if you email or call me individually, that information also will be shared with your partner. If you have an issue that you feel needs to remain private, then you may ask me for a referral to an individual therapist.

(Signature)

(Date)

(Signature)

(Date)

(Therapist’s Signature)

(Date)

Cancellation Policy

In order to accommodate the needs of all my clients and potential clients during the limited times I have available, it is necessary to have a cancellation policy that is fair and reasonable for all parties.

In the spirit of showing respect for each other's time, the following policy was created.

To avoid being charged, cancellations must be made two business days in advance. That is, Friday appointments must be cancelled by Wednesday; Thursday appointments must be cancelled by Tuesday; and Wednesday appointments must be cancelled by Monday. In the case of Monday and Tuesday appointments, cancellations must be made by the prior Friday.

There is no charge in the case of injury, serious illness, family emergency, or natural disaster; please just let me know if this is the case. I understand that circumstances can unexpectedly change.

Client agrees to maintain a current credit card on file to be used in the case of cancellations that do not conform to the cancellation policy.

Name on credit
card _____

Credit card number

Expiration date ____/____ Security code on back of card _____

Billing street address:

Street address City Zip