DISCLOSURE STATEMENT AND CONSENT TO TREATMENT
~ Perspectives Therapy Services LLC ~

THERAPIST TRAINING AND CREDENTIALS:

Thank you for choosing *Perspectives Therapy Services* LLC for your emotional, mental, relationship and psychiatry needs. Your therapist with Perspectives has received an advanced degree in one or more of the following fields: marriage, family therapy, social work, professional counseling, or psychiatry. S/he is licensed through the state of Michigan. If s/he holds a limited license or it is required by the particular insurance company, s/he will be supervised by a fully licensed clinician in the practice.

Therapeutically our staff is trained to work with individuals, couples, and families. We make up a group practice and are all independent private practitioners, not affiliated with any medical center or hospital. We are not available for emergency services, and advise that in these cases, your local Community Mental Health agency or your nearest medical center/hospital be contacted. We are not physicians and do not prescribe medications or perform medical procedures, however, with written consent, we look forward to collaborating with family physicians or psychiatrists.

THERAPY SPECIFICS:

Therapy sessions last 45-60 minutes beginning on the hour. Sessions are typically held one to two times per week. Initial sessions are dedicated to assessment, which involves gathering information about you, your family and the problem bringing you to therapy. To gain the full benefits of therapy it is strongly encouraged that you fully participate in the sessions through regular attendance and willingness to try alternative perspectives for both the problem and its solutions.

The initial assessment meeting is charged at **$200**, Psychiatric Evaluation is **$150** for **60-minutes** and the Medication Review is **$90** for **30-minutes**. Subsequent sessions are charged based on time: **45-minute** sessions are billed at **$150** and **60-minute** sessions are **$175**. Obligation for payment is understood not to be dependent upon the client's receiving third party reimbursement from insurance coverage. While the practice certainly supports and encourages clients to pursue the maximum amount of financial reimbursement from third party payers (such as health insurance agencies), it is ultimately the client's responsibility to insure that s/he receives all third party payments for which s/he may be eligible. Perspectives will submit all insurance billing for health insurance companies that we are networked with. **All co-payments are due at the time of service.** There is a returned check fee of **$20.** It is our practice policy to keep a credit card on file for all clients in the practice. You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Therapy for the individual, couple, family system or psychiatric services
- Initial and ongoing assessment
- Treatment planning
- Time spent in consultation with other professionals

Phone contact, other than to schedule appointments, is considered a consultation and billed at $30 per 15 minutes. Report writing is charged at a rate of $150 per hour.

The therapists at PTS do not provide custody evaluations or appear in court. Additionally, evaluations for disability applications are also not completed.

CLIENT RIGHTS AND RESPONSIBILITIES:

Although you may choose to end treatment at any time, you are responsible to attend scheduled sessions. <u>Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of $75 for a missed session and a $150 for psychiatric eval and $90 for medication review</u>. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions and you will be held responsible for the charges as specified above. In cases of excessive absences it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere. If a client owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made as a result of these attempts, PTS contracts with an external collections service that will then pursue settling the amount due.

Information disclosed in session will be kept confidential and not revealed to any other person or agency without your written permission. However, there are exceptional circumstances that require your therapist to share information obtained in a therapy session without your permission. These exceptional situations include: 1) If you threaten serious bodily harm to yourself or another person, your therapist is required by law to inform the intended victim and/or the appropriate law enforcement agency; 2) If your therapist is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and 3) If you reveal information to your therapist about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority.

After you have carefully read this information and have received satisfactory answers to any questions that may have surfaced, please sign this contract below. Anyone over age 18 must sign this form in order to be treated through Perspectives Therapy Services. Parents or legal guardians must sign for persons under 18 years old.

I have read and understand the information provided in this document and agree to the procedures and conditions outlined. I understand that I may terminate therapy at any time and will be financially responsible for those sessions already completed.

Patient name (please print): _____

Patient signature: _____ Date: _____
(Parent signature for minor client)

Provider Signature: _____ Date: _____

At times there are persons who join the therapy process who are not identified as the "patient", however are important to treatment. By signing below you acknowledge this is a health care setting. The protections in place through our practice's HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below.

Signature: _____ Date: _____

Signature: _____ Date: _____

____ Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.

Insurance Consent

By signing below I give permission Perspectives Therapy Services to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

_____ _____
Signature of insured Date

Addendum to Consent to Treatment: Cell Phone Consent

As a contractual therapist at Perspectives Therapy Services I offer you, the client and/or guardian of the client, the privilege and ability of contacting me via cell phone. This communication includes both phone calls as well as text messaging. Know that this information is indeed a privilege that can be revoked if the therapist deems the client to be abusing the privilege. This definition of abuse is left to the discretion of the therapist and may include, but is not limited to: excessive calls and texts despite the therapist addressing the concern or attempting to contact the therapist after normal business hours.

Please know that because you call or text does not mean you will get a reply immediately or at all. Some concerns brought up in a text message are better addressed in the therapy session. Please note that the intention of receiving this therapists' phone number is primarily for scheduling purposes and to increase efficiency of communication.

Providing this number in no way indicates 24-hour access to my services, nor should it be considered an emergency resource. If you are in crisis, you are still instructed to contact your local Community Mental Health agency (listed below), call 911 or go to your local Emergency Room.

Livingston County: (517) 548-0081
Ingham County: (517) 346-8200
Oakland County: (800) 231-1127
Genesee County: (810) 257-3740

Please respect normal business hours when calling or texting.

HIPAA Privacy Disclosure:
Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or texts cannot be guaranteed.

By signing below, I understand and accept the conditions above. Your care at Perspectives Therapy Services will not change should you decline to sign this section of the form. It is completely optional.

_____ _____
Client Signature (or Parent/Legal Guardian Signature if client is a minor) Date

REGISTRATION AND INTAKE FORM

CLIENT CONTACT INFORMATION

_____ _____ _____
Last Name First Name Social Security #

Address_____ City_____ State_____ Zip_____

Please check below if a message can be left at the following numbers
_____ Home phone: (_____)_____ _____ Work phone: (_____)_____
_____ Cell phone: (_____)_____ Cell phone carrier: _____
Email address:_____

APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)
___ Via text message on my cell phone (normal text message rates will apply according to your contract)
___ Via email message to the address listed above
___ Via automated telephone message to my home phone
___ None of the above. I'll remember my appointments on my own

Signature:_____ Date:_____

CLIENT PROFILE INFORMATION

Date of Birth_____ Male____ Female____ Marital Status: Single___ Married____ Other____

Household Member Name Date of birth Relationship to you

_____
_____
_____
_____

Emergency contact:_____
Name Phone number Relationship

BILLING INFORMATION

Responsible Party Name (who pays the bill):_____ SSN:_____

Responsible Party Address: _____
Street City State Zip Code

Primary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

Secondary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

REFERRAL INFORMATION

How did you find out about Perspectives Therapy Services? Check appropriate box

□ Friend(s)/Neighbors □ Family Member □ Physician/Family Doctor □ Web Search/Internet
□ Social Service Agency □ Court System □ School System □ Yellow Pages
□ Other (please specify)_____

May we send a general thank-you to this referring source? □ Yes □ No
If yes, where should this be sent? _____

PREVIOUS THERAPY EXPERIENCE

Have you received mental health services (counseling/therapy) in the past? _____Yes _____No
If yes,……..When?_____Where or with whom?_____
For what reason?_____

What was *most* helpful about this therapy experience?_____
_____

What was *least* helpful about this previous therapy experience?_____
_____

MEDICAL BACKGROUND

Primary Care Physician_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Please list any medications you are taking at this time.

Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking

Have you ever been hospitalized for reasons relevant to your attending therapy? □ Yes □ No
If yes, please describe_____

PROBLEM SPECIFICATION

Briefly describe what brings you to therapy at this time_____
_____
What would you like to see happen as a result of therapy? _____
_____

Office Use Only

Therapist initials:_____ Location: B L Hi F Diagnosis:_____ Supervisor:_____
USERNAME: PASSWORD:

Thank you for providing the information requested on this form. This is considered confidential information and will not be shared with anyone other than your therapist unless permission is granted through written consent.

PERSPECTIVES THERAPY SERVICES LLC

Adult History and Symptom Questionnaire

Basic background information

First name:_____ M.I. _____ Last name:_____ Today's Date:_____

What type of therapy are you seeking (check all that apply)? ☐ Individual ☐ Couple ☐ Family

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

How many times have you been married? _____ How long in current marriage?_____

Religious affiliation: _____ Military history: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed not looking for work ☐ Unemployed looking for work ☐ Self-employed ☐ Retired

Job title:_____ Company name:_____

Education: Highest Grade Completed _____ Degree:_____ Other:_____

Current concerns

☐ Loss of loved one through death	☐ Separation from loved one	☐ Divorce	☐ Trauma
☐ Care of elders/loved ones	☐ Marriage difficulty	☐ Lifecycle transition	☐ Low self-worth
☐ Change of jobs	☐ Employment concerns	☐ Stress	☐ Abortion
☐ Spouse/significant other conflict	☐ Family conflict	☐ Parenting issues	☐ Co-dependency
☐ Custody issues	☐ Pregnancy	☐ Fertility issues	☐ Victim of emotional abuse
☐ Behavior of adult children	☐ Gender identity	☐ Worry/anxiety interfering with life	☐ Suicidal thoughts
☐ Health problems	☐ Victim of physical abuse	☐ Financial problems	☐ Suicidal behaviors
☐ Substance abuse	☐ Gambling	☐ Eating disorder	☐ Phobia (specific fear)
☐ Excessive computer/electronics use	☐ Sexual orientation exploration	☐ Sexual assault/rape	☐ Legal problems
☐ Pornography seeking behaviors	☐ Violent/abusive behavior	☐ Residual childhood experiences	☐ Employment problems
☐ Interpersonal problems	☐ Unhappy, feeling depressed	☐ School problems	☐ Other:_____

Symptoms

☐ nervousness	☐ dizziness/headaches	☐ fainting spells	☐ heart palpitations	☐ stomach trouble
☐ anxiety	☐ bowel disturbances	☐ nightmares	☐ feel tense	☐ tremors
☐ unable to relax	☐ shy with people	☐ sleep difficulties	☐ overambitious	☐ unmotivated
☐ uneasy in social situations	☐ inferiority feelings	☐ can't keep a job	☐ lonely	☐ impulsivity
☐ excessive sweating	☐ difficulty making decisions	☐ wanting to run away	☐ persistent worrying	☐ indecisiveness
☐ weight loss (_____ lbs.)	☐ weight gain (_____ lbs.)	☐ panic attacks	☐ memory problems	☐ loss of interest in activities
☐ difficulty concentrating	☐ withdrawn/avoid others	☐ decreased energy	☐ drink too much alcohol	☐ irritability
☐ quick to anger	☐ overeat/binge	☐ restrict food	☐ self-harm behaviors	☐ suicidal thoughts
☐ abuse recreational drugs	☐ abuse prescription meds	☐ crying episodes	☐ exercise excessively	☐ mood swings
☐ loss of interest in sex	☐ pornography addiction	☐ negative body image	☐ poor boundary setting	☐ racing thoughts
☐ obsessive thoughts	☐ inattention	☐ lack of focus	☐ lack of motivation	☐ easily distracted
☐ self-critical	☐ poor work performance	☐ teeth grinding	☐ aggressive behaviors	☐ fatigue

Other: ☐_____ ☐_____ ☐_____ ☐_____

Self-care

Check all the following areas of support that you use:
☐ Nuclear family ☐ Church/mosque/temple ☐ Spouse/intimate partner ☐ Extended family ☐ Group of friends ☐ 12-step or similar program ☐ Service system ☐ Close friend

Specifically what do you do (indicate now or in the past) to take care of yourself:

☐ Plenty of sleep ☐ Balanced nutrition ☐ Watch television or movies ☐ Use social media
☐ Meditate ☐ Pray ☐ Exercise/Movement (yoga) ☐ Engage socially
☐ Journal/write ☐ Listen to or play music ☐ Positive self-talk (affirmations) ☐ Artistic expression (draw, paint)
☐ Take time to laugh ☐ Block out time for self ☐ Go to therapy ☺ ☐ Read What else?:☐_____

Strengths

☐ bright ☐ insightful ☐ motivated ☐ good leader ☐ optimistic
☐ able to self-regulate emotions ☐ have friends ☐ can calm myself ☐ resourceful ☐ responsible
☐ can ask for help ☐ keep my boundaries ☐ morally ethical ☐ can solve problems ☐ grateful
☐ able to forgive ☐ can express feelings ☐ financially wise ☐ brave/courageous ☐ hopeful
☐ sense of humor ☐ compassionate/kind ☐ patient ☐ good listener ☐ open-minded
☐ stable employment ☐ able to say "no" ☐ active ☐ creative ☐ willing to try new attitudes & behaviors ☐ persistent

Medical/Psychiatric History Please check any illness you currently have or have had in the past:

☐ Diabetes ☐ High/Low Blood Pressure ☐ Lung Disease ☐ Heart Disease ☐ Low Blood Pressure
☐ Asthma ☐ Cancer ☐ Any Sexually Transmitted Illness ☐ Arthritis ☐ Substance Abuse
☐ Seizures ☐ Traumatic Brain Injury ☐ Migraines ☐ Thyroid Disease ☐ AIDS/HIV
☐ Depression ☐ Auto-Immune Disorders ☐ Cirrhosis ☐ Muscular Disorder ☐ Nerve Disorder
☐ Bi-polar Disorder ☐ Personality Disorder ☐ Anxiety Disorder ☐ Attention Deficit Disorder ☐ Psychotic Disorder (such as schizophrenia)
☐ Ulcer ☐ Colitis/IBS ☐ Learning Disorder ☐ Eating Disorder ☐ Other (please describe) _____

Which relatives have experienced any mental health or substance abuse related problems?

_____ _____
Family member/relationship to you Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you Psychiatric concern/diagnosis

Is there anything else you would like me to know about your medical history?

_____

Risk Assessment

Caffeine consumption: What is your typical caffeinated drinks of choice? (circle one) Coffee Tea Soda _____ ounces/day

Nicotine use: Do you currently smoke cigarettes? ☐ Yes ☐ No **Recreation drug use?** ☐ Yes ☐ No

Alcohol consumption: What is your typical drink of choice? (circle one) Beer Wine Liquor
Estimated daily or weekly consumption: _____ cans/bottles/glasses,ounces**/day** or _____ cans/bottles/glasses,ounces/**week**

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Have you ever made a suicide attempt? ☐ Yes ☐ No If yes, when and how?_____

Has anyone close to you made a suicide attempt? ☐ Yes ☐ No Has anyone close to you completed suicide? ☐ Yes ☐ No

PERSPECTIVES THERAPY SERVICES LLC

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Religious affiliation: _____ Military history: _____

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Job title:_____ Company name:_____

Education: Highest Grade Completed _____ Degree:_____ Other:_____

Current concerns

☐ Loss of loved one through death	☐ Separation from loved one	☐ Divorce	☐ Trauma
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☐ excessive sweating	☐ difficulty making decisions	☐ wanting to run away	☐ persistent worrying	☐ indecisiveness
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☐ self-critical	☐ poor work performance	☐ teeth grinding	☐ aggressive behaviors	☐ fatigue

Other: ☐_____ ☐_____ ☐_____ ☐_____

Self-care

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☐ Nuclear family ☐ Church/mosque/temple ☐ Spouse/intimate partner ☐ Extended family ☐ Group of friends ☐ 12-step or similar program ☐ Service system ☐ Close friend

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☐ Take time to laugh ☐ Block out time for self ☐ Go to therapy ☺ ☐ Read What else?:☐_____

Strengths

☐ bright ☐ insightful ☐ motivated ☐ good leader ☐ optimistic
☐ able to self-regulate emotions ☐ have friends ☐ can calm myself ☐ resourceful ☐ responsible
☐ can ask for help ☐ keep my boundaries ☐ morally ethical ☐ can solve problems ☐ grateful
☐ able to forgive ☐ can express feelings ☐ financially wise ☐ brave/courageous ☐ hopeful
☐ sense of humor ☐ compassionate/kind ☐ patient ☐ good listener ☐ open-minded
☐ stable employment ☐ able to say "no" ☐ active ☐ creative ☐ willing to try new attitudes & behaviors ☐ persistent

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☐ Depression ☐ Auto-Immune Disorders ☐ Cirrhosis ☐ Muscular Disorder ☐ Nerve Disorder
☐ Bi-polar Disorder ☐ Personality Disorder ☐ Anxiety Disorder ☐ Attention Deficit Disorder ☐ Psychotic Disorder (such as schizophrenia)
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Family member/relationship to you Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you Psychiatric concern/diagnosis

_____ _____
Family member/relationship to you Psychiatric concern/diagnosis

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_____

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Are you currently having suicidal thoughts? ☐ Yes ☐ No

Have you ever made a suicide attempt? ☐ Yes ☐ No If yes, when and how?_____

Has anyone close to you made a suicide attempt? ☐ Yes ☐ No Has anyone close to you completed suicide? ☐ Yes ☐ No

PERSPECTIVES THERAPY SERVICES LLC
Relationship History and Symptom Questionnaire

Basic Background Information

Name of person completing this form:_____ Date of Birth:_____

Partner's name:_____ Date of Birth:_____

Relationship Status

Check all that apply

☐ Married ☐ Separated ☐ Divorced ☐ Dating ☐ Engaged ☐ Living together ☐ Living apart

Length of time in current relationship?_____

Do you have children together? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Self): How many times have you been married? 1 2 3 4 5+ Duration(s) of previous marriage(s):_____

Do you have children from previous relationships? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Partner): How many times have you been married? 1 2 3 4 5+ Duration(s) of previous marriage(s):_____

Do you have children from previous relationships? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Quality of Current Intimate Relationship

On a scale of 1 to 5, rate the following items. 1=Poor or Low, 5 = Great or High

(If not applicable, leave blank)	Present State of Relationship	My Own Need or Desire for it	Partner's Need or Desire for it
1. Affection	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. Emotional Closeness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3. Commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4. Communication	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5. Child-rearing agreement	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6. Financial security	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7. Honesty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8. Housework shared	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
9. Physical attraction	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
10. Religious commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
11. Respect	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
12. Social life together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13. Time together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
14. Trust	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
15. Decision-making	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
16. Sexual fulfillment/enjoyment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
17. Sexual frequency	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Behaviors During Conflict

	ME					MY PARTNER				
	Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always
1. Apologies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Become silent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Bring up the past	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Criticize	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Cruel accusations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Cry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Destroy property	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Leave the house	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Make peace	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Namecall	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Light-hearted joke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Not listen	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Hit, push, kick	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Physical threats	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Sarcasm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Yell	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Slam doors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Defensive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Ask clarifying ?s	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Validating responses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21. Express emotions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22. Invite dialogue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23. Speak calmly	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24. Escalate	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25. Threaten breaking up	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26. Tender touch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27. Caretaking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28. Threaten to take kids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29. Throw things	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30. Verbal attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31. Eye rolling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32. Threaten to hurt self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33. Take time out to calm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34. Use alcohol or drugs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35. Threaten to hurt other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PERSPECTIVES THERAPY SERVICES LLC
Relationship History and Symptom Questionnaire

Basic Background Information

Name of person completing this form:_____ Date of Birth:_____

Partner's name:_____ Date of Birth:_____

Relationship Status

Check all that apply

☐ Married ☐ Separated ☐ Divorced ☐ Dating ☐ Engaged ☐ Living together ☐ Living apart

Length of time in current relationship?_____

Do you have children together? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Self): How many times have you been married? 1 2 3 4 5+ Duration(s) of previous marriage(s):_____

Do you have children from previous relationships? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Partner): How many times have you been married? 1 2 3 4 5+ Duration(s) of previous marriage(s):_____

Do you have children from previous relationships? ☐ Yes ☐ No

If yes, what are the children's names and ages?_____

Quality of Current Intimate Relationship

On a scale of 1 to 5, rate the following items. 1=Poor or Low, 5 = Great or High

(If not applicable, leave blank)	Present State of Relationship	My Own Need or Desire for it	Partner's Need or Desire for it
1. Affection	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
2. Emotional Closeness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
3. Commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
4. Communication	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5. Child-rearing agreement	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6. Financial security	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7. Honesty	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8. Housework shared	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
9. Physical attraction	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
10. Religious commitment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
11. Respect	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
12. Social life together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
13. Time together	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
14. Trust	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
15. Decision-making	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
16. Sexual fulfillment/enjoyment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
17. Sexual frequency	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Behaviors During Conflict

	ME					MY PARTNER				
	Never	Rarely	Sometimes	Frequently	Always	Never	Rarely	Sometimes	Frequently	Always
1. Apologies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Become silent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Bring up the past	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Criticize	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Cruel accusations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Cry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Destroy property	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Leave the house	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Make peace	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Namecall	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Light-hearted joke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Not listen	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Hit, push, kick	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Physical threats	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Sarcasm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Yell	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Slam doors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Defensive	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Ask clarifying ?s	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Validating responses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21. Express emotions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22. Invite dialogue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23. Speak calmly	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24. Escalate	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25. Threaten breaking up	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26. Tender touch	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27. Caretaking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28. Threaten to take kids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29. Throw things	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30. Verbal attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31. Eye rolling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32. Threaten to hurt self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33. Take time out to calm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34. Use alcohol or drugs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35. Threaten to hurt other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36. _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

~ Perspectives Therapy Services, LLC ~

Medical Provider Coordination of Care

(Authorization to Disclose Protected Health Information)

Client name: _____ DOB: _____

In order to provide you with the highest quality care, we ask your permission to communicate with your primary care physician (PCP) or psychiatrist. This is also a requirement of most health insurance companies and therefore part of our compliancy contract with these payors.

Please read & check the appropriate box. If you do want information to go to your medical provider, then check the "**YES"** box and sign below. If you do not want information to go to your medical provider, then check the **"NO**" box and sign below.

☐ **Yes** ☐ **No** I do hereby authorize/give my permission to exchange information with my medical provider listed below regarding my mental health treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or substance abuse care and/or treatment such as diagnosis, estimated length of treatment, type of treatment to be provided and the treatment plan. I also understand that my therapist will provide my medical provider with periodic status reports of my progress during the course of treatment.

I further understand that the authorization shall remain in effect for one (1) year from the date of my signature or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my therapist at Perspectives Therapy Services. I also understand that it is my responsibility to notify my therapist if I choose to change my medical provider.

Medical Provider name: _____ Fax number:_____

Practice name:_____ Practice phone number:_____

Practice address:_____

_____

Psychiatrist name: _____ Fax number:_____

Practice name:_____ Practice phone number:_____

Practice address:_____

Client/Guardian Signature _____ Date: _____

Witness:_____ Date: _____

Credit Card Authorization

Perspectives Therapy Services LLC uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists.

The following are examples of charges that will be charged to the credit card on file: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees, and returned check fees.

Type of Card (check one): ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

Type of Card (circle one): CREDIT HSA/FSA DEBIT

Name of Cardholder:_____

Card No._____

Expiration date:_____ CVV2 (security code):_____

Client address:_____
Street City State Zip Code

Authorizing signature:_____ Date:_____

Client name (printed):_____

*This card will be used for any and all providers with whom a client receives services from through Perspectives Therapy Services. It is the client's responsibility to update credit card information with our practice as changes occur.

For Office Use Only: