Perceptions Wellness
24050 Madison Street, Suite 200,
Torrance, CA 90505 • Ph: (424) 323-6230

Welcome. We look forward to working with you. This form requests information about you and/or your family that will help me plan your care. If you have any questions, please feel free to discuss them with me.

Reset From

Patient Name _____ today's Date _____

Address _____ Birthdate _____

City, State, Zip _____ __ Age

_____

Phone # (_____)_____ (_____)_____ (_____)_____

Home OK to leave messages? ◯Y ◯N **Work** OK to leave messages? ◯Y ◯N **Cell** OK to leave messages? ◯Y ◯N

Occupation_____ E-mail_____

Emergency Contact _____
Name Relationship to patient phone number

Name & phone of primary care physician_____

Name & phone of psychiatrist (if any)_____

Primary Insurance Information:

Insured Name: _____

Insured SSN: _____

Insured DOB: _____

Employer: _____

Mental Health Carrier: _____

Relationship to Insured:_____

Member No:_____

Policy/Group No:_____

Benefit Information:

Insurance Company:_____

Address:_____

Telephone:_____

Authorization No:_____

Copay Amount:_____

Max. Visits:_____

Areas of Concern:

Please describe your reason(s) for seeking treatment at this time (include date the problem started):_____

_____

_____

Was there an event that made these issues or problems surface? ◯ Y ◯ N If yes, please describe: _____

_____

Do you have any specific goals for treatment? What result(s) do you expect from treatment?_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?_____

_____

Other Information:

Please describe your spiritual/religious orientation_____

Please describe your interests/hobbies_____

Are you now or have you ever been involved in a lawsuit? ◯ Y ◯ N Please describe_____

_____

Has anyone in your family had a serious medical illness? If so, please explain what/when: _____

Has anyone in your family had a psychiatric (nervous or mental) illness? ◯ Yes ◯ No If yes, please explain what/when:

_____

Any medication? ◯ Y ◯ N What? _____ Hospitalization? ◯ Y ◯ N When?_____

Please feel free to include any other information that you believe is relevant to your mental health treatment_____

_____

_____

Please indicate & rate the severity (1-4) of the following issues or problems you would like to work on in treatment:

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
____Anger/temper	____Diet	____Motivation	____Headaches
____Depression	____Anxiety	____Controlling stress	____Loss of loved one
____Problems at school	____Problems at work	____Lack of friends	____Loneliness
____Problems coping	____Abuse/victimization	____Financial problems	____Legal matters
____Panic	____Concentration	____Sleep	____Fears
____Body Image	____Nightmares	____Energy	____Divorce/Separation
____Marriage/Relationship issues	____Sexuality/Sexual issues	____Family conflict	____Behavioral problems
____Drug/alcohol habit	____Relaxation	____ADD/ADHD	____Shyness
____Self-control	____My thoughts	____Eating Disorder	____Being a parent

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e., overeating, Hoarding, checking, counting, washing, illness-related, thoughts of harming someone, sexual behavior, etc.)? _____Yes _____No
If yes, please describe:_____
_____

MEDICAL

When were you last examined by a physician?_____ Outcome?_____

Medications

Type	**Dosage**	**Start Date**	**Prescribing M.D.**	**Phone No.**

_____

_____

_____

Side Effects_____

_____

Alternative treatments_____

Allergies

Type_____ Severity_____ Treatment_____

Type_____ Severity_____ Treatment_____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc.

_____

_____

IMMEDIATE FAMILY

LIST MEMBERS OF YOUR FAMILY OR OTHERS WITH WHOM YOU LIVE:

Name(s)	**Age**	**Relationship**	**Occupation**

Marital Status

- ◯ single, never married
- ◯ engaged ____ mos.
- ◯ married _____ yrs.
- ◯ divorced ____ yrs.
- ◯ separated ___ yrs.
- ◯ divorce in process ___ mos.
- ◯ live-in for ____ yrs.
- ◯ prior marriages (self)
- ◯ prior marriages (partner)

Intimate Relationship

- ◯ never been in serious relationship
- ◯ not currently in relationship
- ◯ currently in serious relationship

Relationship satisfaction

- ◯ very satisfied w/relationship
- ◯ satisfied with relationship
- ◯ somewhat satisfied w/relationship
- ◯ dissatisfied w/relationship
- ◯ very dissatisfied w/relationship

List minor children NOT living in same household

Name	Age	Sex	Relationship

Frequency of visitation of above:_____

_____

_____

Describe any part or current significant issues in **intimate** relationships:_____

_____

Present during childhood:

	Present Entire Childhood	Present part of childhood	Not present at all
Mother	☐	☐	☐
Father	☐	☐	☐
Stepmother	☐	☐	☐
Stepfather	☐	☐	☐
Brother(s)	☐	☐	☐
Sister(s)	☐	☐	☐

Family alcohol/ Drug Abuse History:

- ☐ Father
- ☐ Mother
- ☐ Grandparent
- ☐ Sibling(s)
- ☐ Other_____
- ☐ Stepparent/Live-In
- ☐ Uncle(s)/Aunt(s)
- ☐ Spouse/Partner
- ☐ Children

Parents' current marital status:

- ☐ married to each other
- ☐ separated for _____ years
- ☐ divorced for ____ years
- ☐ mother remarried _____ times
- ☐ father remarried _____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for ___ years
  age of patient at mother's death __
- ☐ father deceased for ____ years
  Age of patient at father's death ___

SUBSTANCE USE HISTORY (check all that apply for patient):

Self-Perception of substance use:
Amount

- ☐ **none**
- ☐ Occasional/social
- ☐ Problem use
- ☐ Dependent
- ☐ don't want to stop
- ☐ Addicted/Cannot stop
- ☐ Motivated to stop

Previous treatment:

- ☐ 12-Step
- ☐ Out Patient
- ☐ In Patient

Substances used:	**First use age**	**Last use age**	**Current?**	**Frequency**
☐ **alcohol**				
☐ amphetamines/speed				
☐ barbiturates/downers				
☐ cocaine/crack				
☐ hallucinogens (LSD, etc.)				
☐ inhalants (glue, etc.)				
☐ marijuana or hashish				
☐ PCP/Ecstasy				
☐ prescription drugs				
☐ nicotine/cigarettes				
☐ caffeine				
☐ other _____				

Physical/mental consequences of substance use (check all that apply):

- ☐ Outpatient (age(s)_____)
- ☐ Inpatient (age(s)_____)
- ☐ 12-step program (age(s)_____)
- ☐ stopped on own (age(s)_____)
- ☐ other (age(s)_____
  Describe:_____

- ☐ hangovers ☐ binges ☐ blackouts ☐ job loss
- ☐ seizures ☐ overdose ☐ arrests/DUI ☐ assaults
- ☐ withdrawal symptoms ☐ sleep disturbances
- ☐ medical conditions ☐ tolerance changes
- ☐ relationship conflicts ☐ suicidal impulse
- ☐ loss of control of amt used ☐ other _____

The following information is provided to you so you have a better understanding of how your care will be coordinated. Please read each item carefully and sign in the appropriate spaces.

TREATMENT PHILOSOPHY

During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. ***If your insurance is a managed healthcare plan, the number of sessions available to you may be severely limited.*** You are expected to be compliant with the agreed upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

CONFIDENTIALITY:

All information between provider and patient is held strictly confidential unless:

1. Patient authorizes release of information with his/her signature.
2. Patient presents a physical danger to self.
3. Patient presents a danger to others.
4. Child/elder abuse is suspected.
5. Patient fails to pay for services rendered and formal collection becomes necessary.

We are required by law to inform potential victims and legal authorities so protective measures can be taken.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your treatment and your provider will be paid directly by the carrier. You will be responsible for any applicable **deductibles** and **copayments**. Copayments must be paid at the time services are rendered. If you are not eligible for benefits at the time services are rendered, you are responsible for full payment of provider's hourly rate, which is $_____. Your copayment for services is $_____. **Patient initials** _____

CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. ***If an appointment is missed or canceled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan***. Most health plans do not cover payment for missed appointment; therefore, you are responsible for payment in full. **Patient initials** _____

APPEALS AND GRIEVANCES

I acknowledge my right to request an appeal in case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance carrier. I also understand that I may submit a grievance to my provider at any time to register a complaint about my care. I also understand the California Department of Managed Care (DMC) regulates health services. Their telephone number is 800-400-0815, and I may contact them to register a complaint against my health care plan.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the office telephone message and your call will be returned. If you experience a true life threatening emergency and need immediate attention, you should leave a message for your provider and then call 911 or go to the nearest hospital emergency room.

RELEASE OF INFORMATION TO HEALTH PLAN

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan. **Patient initials** _____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

I authorize the release of information to my Primary Care Physician (name)_____ at (telephone number)_____ for purposes related to my health care. **Patient initials** _____

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services described on Form HCFA-1500.

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

SIGNED _____ Date_____

I understand and agree to all of the above information.

_____

Patient (or Parent/Guardian) Name – *Printed* Date

_____

Patient (or Parent/Guardian) Name – *Signature* Date