Charles M. Iker,
LCSW, ACSW, BCD

C M I
PSYCHOTHERAPY

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INTAKE/BIOPSYCHOSOCIAL HISTORY QUESTIONNAIRE

GENERAL INFORMATION

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

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____Work Phone #: _____Cell Phone #: _____

May we leave discrete messages at the above-listed numbers? ❒ Yes ❒ No

Email Address: _____

May we send you confidential information through email (using a secure, encrypted server)? ❒ Yes ❒ No

Age: _____ Gender (Male, Female): _____ Social Security #: _____

Name and Phone # of Emergency Contact Person: _____

How did you hear about Charles M. Iker, LCSW?: _____

Briefly describe what brings you to this appointment and/or what you would like to accomplish:

_____

_____

POLICIES

EVALUATION POLICY

My objective is to conduct a thorough and comprehensive evaluation of your life history which includes mental health history and drug alcohol history. Based on this evaluation of your difficulties and your stated goals for therapy I will be able to make appropriate recommendations regarding your treatment.

The fee associated with the initial evaluation will in most cases be set by your respective insurance companies. The same will hold true for folling individual therapy sessions.

If I need to spend more that an hour's time writing reports or gathering material to communicate with other professionals I will bill that time at my normal hourly rate of $125 an hour.

In cases where you are not using insurance the sessions will be billed out at a flat $125 an hour.

You are welcome to ask questions and I will gladly help you find resources for alternative/second opinon evaluations.

If it is deemd that you require a different level of care or if a different therapist is indicated with an expertise in an area I am not comfortable working with or if you would feel more comfortable working with a different therapist, all efforts will be made to assist with and make the most appropriate referrals for treatment or education.

While you are legally entitled to confidentiality, you may need to provide consent for us to report to your employer or some agency. This is at your discretion.

In order to complete your evaluation, we may need to collect information from other sources to supplement your self-report, such as interviews with family members, other healthcare providers, probation officers, etc. If this evaluation will be used in a court proceeding, we will ask for a copy of the court order for the evaluation and other legal documents. The evaluator may also obtain information online or through public records relevant to your legal history, both criminal and civil.

FINANCIAL POLICY

Full payment is preferred at the time of service as it makes my accounting process much easier.
Please feel free to ask if you have any questions about my financial policy. Understanding my financial policy is important to our relationship. Insurance is a contract between you and your insurance company. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e. diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice.

CANCELLATION POLICY

If you need to cancel or reschedule please give me as much notice as possible so I can offer that time to someone else in need. Unless cancelld at least 24 hours in advance my policy is to charge a no show fee of 60 dollars.

CONFIDENTIALITY

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). I will not share information with any person outside of my practice without your written permission, except as required by law or as needed to file your insurance claim. Information obtained from minors is not generally shared with parents without permission.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability, or any reported sexual misconduct by a licensed health care provider. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

CONSENT TO TREATMENT

I am voluntarily seeking outpatient counseling with Charles M. Iker, LCSW . I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly

encouraged to discuss my treatment plan and status in treatment. I will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. **With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at CMI Psychotherapy.**

_____ _____

Signature of Client and/or Legal Guardian Date

STRENGTHS

Tell us about your strengths, skills, abilities, and positive traits: _____

_____

_____

_____

DEVELOPMENTAL HISTORY

Now we're going to ask some questions about your birth and early childhood.

Where were you born? _____

How was your mother's health during her pregnancy with you? _____

Were there any complications with your birth? _____

To your knowledge, did you mother use tobacco, alcohol, or other drugs during her pregnancy with you? _____

_____

Are you aware of any delays or difficulties during your early childhood (e.g. speaking, toilet training, crawling, walking, etc.)? _____

_____

Did you experience any medical problems or serious injuries during childhood? _____

_____

FAMILY HISTORY

Is your father living? _____ Father's age: _____ Where does your father live? _____

Father's occupation: _____ Father's values growing up: _____

Describe your relationship with your father now: _____

What was your relationship with your father like growing up? _____

Is your mother living? _____ Mother's age: _____ Where does your mother live? _____

Mother's occupation: _____ Mother's values growing up: _____

Describe your relationship with your mother now: _____

What was your relationship with your mother like growing up? _____

Describe your parents' relationship with each other when you were a child: _____

_____

What is it like now? _____

Were you adopted? _____ If so, what do you know about your birth parents? _____

_____

Do/did you have step-parents? _____ If so, describe your relationship: _____

List the names and ages of your brothers and sisters: _____

_____

Where are you in the birth order? ❒ Oldest ❒ Youngest ❒ Middle

Describe any major cultural or religious influences in your family: _____

_____

Describe your family growing up: _____

_____

Describe your childhood: _____

Did you experience physical, sexual, or emotional abuse or neglect growing up? _____

If so, please describe: _____

Do you know of any other traumatic events while growing up? _____

If so, please describe: _____

Do any family members have a history of mental illness or a problem with alcohol or drugs?

Family Member(s)	Yes	No	Describe:
Mother			
Father			
Siblings			
Step-parents			
Aunts/Uncles			
Grandparents			
Children			
Spouse/partner			

How did the family you grew up in affect who you are today? _____

_____

EDUCATIONAL, VOCATIONAL, AND FINANCIAL HISTORY

What was school like for you growing up? _____

Highest grade completed: _____ Current employment status: _____

What has been your major field of employment (trade, profession)? _____

If you ever served in the military, describe your service (branch, rank, length of service, discharge type, disciplinary proceedings, etc.): _____

_____

What is your current annual income (or hourly wage)? _____

Do you have any concerns about money? What are they? _____

Do you get the sense that you can afford your bills? _____

Do you have extensive debt? If so, about how much do you owe? _____

Have you ever filed for bankruptcy? If so, when? _____

LEGAL HISTORY

Arrest history (dates and charges): _____

_____

Describe any current legal issues (e.g. probation, pending charges): _____

_____

SOCIAL AND SPIRITUAL HISTORY

Where/with whom do you currently live? _____

What do you do in your spare time? _____

What mode(s) of transportation do you use? _____

Do you have problems with transportation? What are they? _____

Who do you turn to for support? _____

What percentage of your friends drink/use drugs? _____

What have your friends, family, and loved ones said about your drinking or drug use? _____

_____

If you were to quit or cut back on alcohol or drug use, who would/would not be supportive? _____

_____

Number of marriages/partners: _____ Current marital/partner status: _____

If you are in a relationship, how long have you been in it? _____

If you have children, list names and ages: _____

Which children are living with you? _____

Describe your current religious or spiritual beliefs and practices: _____

_____

SEXUAL HISTORY

What is your sexual orientation? ❒ Heterosexual ❒ Bisexual ❒ Homosexual ❒ Other

How did you learn about sex? _____

Were you using alcohol or drugs during your first sexual experience? _____

How has alcohol or drug use affected your sex life? _____

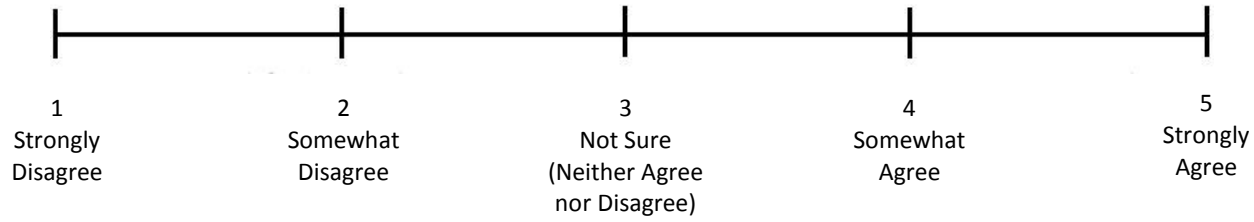
Describe any current or past sexual concerns: _____

SUBSTANCE USE HISTORY (LIFETIME)

Substance	Age 1st Used	Date Last Used	Amount (range from least to most)	Frequency (how often)	Circumstances of Use	Used in past week?
Alcohol						
Amphetamines/ Stimulants						
Barbiturates						
Benzodiazepines (e.g. Xanax, Klonopin, Valium)						
Caffeine						
Club Drugs (e.g. Ecstasy, GHB, roofies)						
Cocaine						
Hallucinogens (e.g. LSD, PCP, shrooms)						

Substance	Age 1st Used	Date Last Used	Amount (range from least to most)	Frequency (how often)	Circumstances of Use	Used in past week?
Heroin						
Inhalants						
Marijuana						
Other Opiates (e.g. pain medication)						
Steroids						
Synthetic Marijuana (e.g. K2, Spice)						
Tobacco						
Other: _____						

Please rate how strongly you agree or disagree with the following statements on a scale from 1 to 5 using the scale below. Please place the number that best fits in the blank next to each statement.



_____ I have a problem with alcohol or drugs.

_____ I am open to exploring whether or not I have a problem with alcohol or drugs.

_____ I would like to change something about my alcohol or drug use.

_____ I have developed a plan for changing my alcohol and drug use.

_____ I am already working on my problem with alcohol or drugs.

_____ I haven't had a problem with alcohol or drugs for at least 6 months.

TREATMENT HISTORY

Have you ever participated in any form of counseling or treatment (e.g. mental health counseling, family/couples counseling, detox, substance abuse treatment, psychiatric medication maintenance, etc.)? If so, document in the following chart:

Name of Treatment Facility/Provider	Date(s) of Treatment:	Outcome (e.g. successful completion)	What Was Helpful?	What Wasn't Helpful?

(If you need additional space, please write on back of paper or ask for an extra sheet.)

MEDICAL HISTORY AND SCREENING

How would you describe your current health? _____

Do you have any medical concerns? _____

Are you receiving any medical treatment? What type? _____

When was your last physical exam? _____ Do you have a primary doctor? _____

Do you have health insurance or coverage? If so, what type? _____

How many hours of sleep do you get in an average night? _____

Do you experience any difficulty with sleep (e.g. difficulty falling or staying asleep, troubling dreams, etc.)? _____

_____

Do you exercise regularly? ❒ Yes ❒ No If so, please describe: _____

_____

How many meals do you eat in a typical day? _____ How many times do you snack in a day? _____

Describe your diet (e.g. what you eat, portion sizes, etc.): _____

_____

Do you have any allergies? What are they? _____

List all the medications you are taking:

Medication	Dosage/Frequency	Purpose	Prescribing Physician

(If additional medications, please provide us with a list or ask for a separate sheet of paper.)

Do you or have you ever experienced any of the following?

CONDITION	Current (X)	Past (indicate when)	CONDITION	Current (X)	Past (indicate when)
Anemia			Head Injury		
Anxiety Disorder			Headaches/ Migraines		
Breathing/ Lung Problems			Heart/ Blood Pressure		
Bowel/ Stomach Trouble			Kidney Problems		
Convulsions/ Seizures			Liver Trouble		
Depression			OB/GYN Problems		
Diabetes			Pancreatitis		
Excessive Bleeding			Other mental or medical problem(s) _____ _____		

Our licensing by the Department of Children & Families requires us to do both screening and education about communicable diseases. New cases of communicable diseases must be reported to the Dept. of Health. We ask people to practice courtesy and general good hygiene including universal precautions and seeing a physician when sick. A copy of our infection control policy is available to you. We will gladly answer questions you may have. Individuals who abuse substances are at higher risk for contracting HIV/AIDS, Hepatitis, Tuberculosis, sexually transmitted infections (STIs), and other communicable diseases. We encourage you to get accurate information and anonymous/confidential testing. **We will gladly help you get anonymous/confidential testing and treatment. There are excellent assistance programs available. Please ask!**

Hepatitis is a disease of the liver. There are several types of Hepatitis and people who are infected may not know it because they don't have symptoms yet. Chronic Hepatitis B & C are two of the most serious types which can be life threatening. Early detection can help save lives because treatment is available. Hepatitis can be transmitted through body fluids such as blood, semen, and vaginal fluids. Most commonly these fluids are exchanged during sexual contact, by piercing & tattooing, or by sharing paraphernalia used to smoke, snort, or shoot drugs. Hepatitis is also transmitted by contact with fecal stool, which is the reason for the signs in restaurant bathrooms. It is generally accepted that Hepatitis is not spread by casual contact. Testing is available through your doctor or at the Health Department. Symptoms of Hepatitis include tiredness or fatigue, flu-like symptoms, loss of appetite, nausea, vomiting, fever, and weakness. You can protect yourself from exposure by abstaining from sex and drug use. Safer sex and not sharing paraphernalia reduce exposure risks. We have handouts that provide additional information.

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). People with HIV/AIDS may look healthy. Again, early detection can lead to life preserving and life enhancing treatment. HIV/AIDS can be transmitted through body fluids such as blood, semen, vaginal fluid, and sometimes breast milk. It is transmittable through oral, anal, and vaginal sex. It is transmittable through the sharing of needles including those used for drugs, piercing, and tattooing. HIV/AIDS is not spread through casual contact. Anonymous testing is available at the Health Department. Symptoms of AIDS often do not occur for many years after infection with HIV, and the infected person is contagious during this time. Again testing can save the lives of others as well as help the infected person receive proper treatment. You can protect yourself from exposure by abstaining from sex and use of needles. Safer sex including avoiding high-risk behavior reduces exposure risks. We have handouts available for more information.

Tuberculosis is a disease spread from person to person through germs in the air. Tuberculosis usually affects the lungs, but can affect other organs. More powerful strains of Tuberculosis are occurring and infection is on the rise. There are higher risk situations including exposure to confined spaces such as institutions or planes. Testing is available through your doctor or at the Health Department. Symptoms of Tuberculosis include feeling sick or weak, weight loss, fever, night sweats, cough, coughing up blood, and chest pain. We ask that people practice coughing into their elbow. For a demonstration or for additional information, please ask.

SCREENING:

HAVE YOU EVER...?	YES (X)	NO (X)	DO YOU CURRENTLY HAVE...?	YES (X)	NO (X)
Shared a needle?			Night sweats?		
Had a tattoo or piercing?			Fatigue?		
Had sex with a prostitute?			Flu-like symptoms?		
Had sex for money or drugs?			Cough?		
Had unprotected sex outside a monogamous relationship?			Coughing up blood?		
Had multiple sex partners in the past year?			Fever?		
Had a sexually transmitted disease/infection?			When was your last HIV test? _____		
Had a blackout while drinking/using drugs?			Your last Hepatitis test? _____		
Had sex with someone who would answer yes to any of these questions?			Your last Tuberculosis test? _____		

I have reviewed and understand the above medical information.

_____ _____

Signature of Client and/or Legal Guardian Date