Abi Joy Nix, M.A. LCPC. 1603 Orrington Ave. Suite 600. IL 60201
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BIOPSYCHOSOCIAL HISTORY

In preparation for our first appointment, please complete the following information to the best of your ability. All information remains confidential. This information will help me to better understand your current life circumstances, your concerns, your strengths, and your goals for seeking psychotherapy at this time. Feel free to leave blank any questions that are not relevant to you or that you would prefer not to answer. In all cases, if more space is needed, please use side or back. Please print all answers.

IDENTIFYING INFORMATION:

Name:	Date of Birth:	Age:
Current Address:	Billing Address: (Only if different from current)	Phone:
Sex:	Place of Birth:	Ethnicity:
Primarily Raised (city/country):	Occupation: Full time or Part time?	Employer:
To what extent do you consider yourself attracted to:	Women ——————-Both	——-——————-— Men
Email address:		

Present Relationship Status: Significant historic relationship that would be important for me to know in our work together:	Length of Relationship:
Partner's Occupation:	Partner's Employer:

Please list the people with whom you presently live.		
Name	Age	Relationship to You

In case of emergency, please list the name and phone number of the person I have permission to contact: Name: Phone number:	Relationship to You:

PSYCHOTHERAPY GOALS:

How did you become aware of my services? (Referral name/source)?
What would you like to work toward while in psychotherapy?
How did you decide that now is a good time to begin psychotherapy?
What do you anticipate being most helpful in relationship with your therapist?

HEALTH AND WELLNESS:

Please indicate which wellness or lifestyle practices you engage in regularly by checking those that apply and elaborating to the right.		
	Exercise:	
	Nutrition Practices:	
	Time in Nature:	
	Contemplative Practices:	
	Community Engagement:	
	Community Service/ Volunteer Activities:	

	Supportive Relationships:	
	Creative Outlets/Play:	
	Recreational Activities:	
	Relaxation:	
	Other	

Present State of General Health (please select one): **(e.g.) Excellent Good Fair Poor**	
Medical Provider: please list the contact information of your present internist or physician:	
Please provide the approximate date of your last complete physical exam:	
Physical Exam results:	
Please state significant medical problems for which you have been or are being treated:	

Sleep: Please describe your present sleeping pattern (e.g. hours per night; restful or not; problems getting to sleep or waking early).
Diet: Please describe your eating patterns (e.g. number of meals & snacks per day, restrictions).
Allergies: Please list which allergies you have and indicate whether they are mild, moderate, or severe:

Head Injuries (if any), please list approximate date and describe:
Please list any accidents or serious injuries you experienced:
Please list approximate dates and nature of any surgical procedures:
Please describe disabilities (education, physical, cognitive) and their accommodation.

Number of pregnancies:	Number of children?
Please describe the current state of your sexual health/functioning.	
If you have ever experienced or been a partner to someone who has experienced pregnancy loss, please elaborate.	
If you or a partner has ever experienced infertility or infertility treatment, please elaborate.	

Please indicate the amount and frequency of use of the following.				
	Present Use		Past Use, if Different	
	Amount/Type	Frequency	Amount/Type	Frequency
Alcohol				
Nicotine				
Caffeine				
Video Games:				
Other Substances				

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MENTAL HEALTH:

Have you worked with a psychotherapist in the past? (Mark w/ "X") _ _Yes. _ _No.
If so please give the approximate dates, type (i.e. individual, couple, family) and duration of the therapy(ies):
What was most useful to you in this work?

Please list all medications you are currently taking:				
Medication	Dose	Start Date	End Date	Was it helpful?

Name and contact information of current psychiatrist or prescribing physician:
Have you ever had a psychiatric hospitalization? (Mark w/ "X") _ _Yes. _ _No.
Dates of hospitalization:
Please describe reason & outcome:
Have you ever made or threatened to carry out a suicide attempt? (Mark w/ "X") _ _Yes. _ _No. If so, please give approximate date(s) and describe.

Have you ever harmed or threatened to harm another person? (Mark w/ "X") _ _Yes. _ _No. If so, please give approximate dates(s) and describe.
Has substance abuse ever been a problem for you? (Mark w/ "X") _ _Yes. _ _No.
If yes, please indicate which substance(s) of preference and duration of use.
If you have ever received treatment for substance abuse, please describe (e.g. inpatient, outpatient, approximate dates, outcomes).
Do you have a history of other addictive behaviors (e.g. food, gambling, sex, video games, pornography, media/technology)? (Place a "X" next to answer) _ _Yes. _ _No. If so, please describe.
Please list any history of trauma, abuse or neglect.

FAMILY OF ORIGIN:

Please provide information about your parents/caregivers.				
	Parent	Parent	Step Parent or Other Caregiver	Step Parent or Other Caregiver
First Name				
Age				
City, State				
No. of Children				
Marital Status				
Education Level				
Occupation				

Physical Health*				
Mental Health*				
If Deceased, Cause/Age/Date				
*** E = Excellent, G = Good, F = Fair, P = Poor**				

Please provide information about your siblings in order of birth, including step/half siblings. Please use side or back if necessary.

	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
First Name					
Age					
City, State					
Relationship Status					
No. of Children					
Education Level					
Occupation					
Physical Health*					
Mental Health*					
If Deceased, Cause/Age/Date					
*** E = Excellent, G = Good, F = Fair, P = Poor**					

Identify and describe a primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.
In general, how was your relationship with this primary caregiver?

Identify and describe another primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.
In general, how was your relationship with this additional caregiver?
How did your parents or caregivers get along with each other while you lived with them?
How are your relationships with each of your parents/caregivers now?
If you had siblings, describe your relationship with them during childhood.
Please describe your current relationships with your siblings:
While growing up, were you ever frightened by a family member? (Mark w/ "X") _ _Yes. _ _No. . If so, please describe, including frequency and intensity.
Did you ever witness a family member(s) being frightened? (Mark w/ "X") _ _Yes. _ _No If so, please describe, including frequency and intensity.
Please indicate relatives with a history of emotional or mental disorder or suicide. If known, please include diagnosis and treatment.
Please note relatives with a history of alcoholism, substance abuse or excessive alcohol use.
Have you ever experienced abuse or harassment? (Mark w/ "X") _ _Yes. _ _No If so, please describe (e.g. physical, sexual, emotional), including when and by whom.
Growing up, what were your favorite rituals or traditions?

RELATIONSHIPS AND CURRENT FAMILY:

If applicable, please give the approximate date your present partner relationship began.						
If applicable, please provide information about your partner and/or children.						
	Partner	Child	Child	Child	Child	Child
First Name						
Age						
City, State						
Relationship Status						
No. of Children						
Education Level						
Occupation						
Physical Health*						
Mental Health*						
If Deceased, Cause/Age/Date						
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If you have a current relationship with a significant other or partner, please describe your experience of the relationship.
What are the strengths of your relationship?
If you have any concerns about your partner relationship, including safety, fear or sexual concerns, please describe them.

Please describe your partner, including her/his characteristics.
Please list any previous marriages or long-term relationships; including length, and if any children resulted from this relationship.

If you are a parent, please briefly describe your relationship with your children.
What has been most satisfying to you as a parent?
What has been most challenging to you as a parent?

RELATIONSHIP WITH SELF AND OTHERS:

To whom, if anyone, do you typically turn for emotional support?
Briefly describe the nature and quality of your closest friendship(s).
Please describe any concerns you have about your friendships or friendship patterns.
What do you believe to be your strengths as a friend?
Describe your personality and temperament.
What ways do you typically prefer to seek comfort when you are distressed?

EDUCATION:

Please state your highest level of education (including discipline and degree).

Please describe the following for grade school, high school, and any higher education.

	Grade School	High School Year graduated_ _	College/Grad School Year(s) graduated:
How were your grades?			
Describe your involvement in extra-curricular activities.			
Describe your relationship with other students, in general.			
Describe your relationship with teachers.			
If ever diagnosed with a learning disability or attention difficulty, please describe.			
*** E = Excellent,**	**G = Good**	**F = Fair**	**P = Poor**

EMPLOYMENT:

How long have you worked at your present job?
What are your specific work responsibilities?
How satisfied are you with your present job?
What aspects of your present job do you enjoy the most?
How are your relationships with your peers at work?

How are your relationships with supervisors?
Please list other significant jobs you have had along with approximate dates.
Please describe any significant problems in past/present job situations.

SPIRITUALITY/FAITH:

If applicable, describe the role spirituality/religion has played in your life.
In what spiritual/religious faith, if any, were you raised?
If you have a present spiritual/religious community, please describe.
How often do you attend religious/spiritual services or activities?
Please describe any spiritual/religious practices you may have.
If applicable, please describe your spirituality or philosophy of life?

LEGAL:

Have you had any past litigation or legal problems? (Mark w/ "X") _ _Yes. _ _No If so, please explain.

OTHER:

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

Do you have any questions for me that relate to our work together?

Therapy:

The clinical relationship is central to the work I provide. As such, I work to establish safety in the therapy relationship, working to earn your trust, so that we can honestly address your concerns and co-create a plan which best addresses your purpose in seeking treatment at this time. Psychotherapy can be tremendously beneficial to some individuals while, at the same time, there are inherent risks in the course of treatment as well. It is my practice to be as transparent as possible about risks to reduce the anxiety new clients have to treatment and to provide a 'roadmap' to identify symptoms in order to be best informed about the new experiences you notice. A significant part of therapy is to become curious about your own process of development. This elevated curiosity creates a necessary and meaningful connection with your own experiences, helping you feel more empowered in the choices you make in your own care.

While each person's response to therapy is unique, generally speaking several risks you may notice in therapy include: an intensity of painful and unwanted feelings such as sadness, anger, guilt, fear, or anxiety. Many of these feelings, while painful and difficult, are natural and to be expected. In fact, they are a necessary and important part of the therapeutic process, as I believe it is necessary to address these risks in order for growth to happen. Other risks may be recalling unpleasant memories, recalling painful losses, and acknowledging our responses to them. Another common concern is the risk of opening up to a new clinician. This concern is valid. I hope as we progress in therapy, the trust assuages the caution and you find ease in communicating your progress toward your goals and improved authenticity in your relationships. When the "client" is a child, it is important to share with Ms. Nix any changes in behavior, mood, or routines following therapy so that she will know the best rate at which to work with the child in therapy so that the child is not overwhelmed.

Abi J. Nix is a Licensed Clinical Professional Counselor (LCPC) in the state of Illinois, whose practice includes adolescents, individuals and at times families. She specializes in treating adolescents and adults with a history of trauma. It is my goal to enhance the functioning and well-being of the families, couples, and individuals with whom she provides therapy. Ms. Nix's primary approach is relational focused psychotherapy, which utilizes the clinical relationships as a way of addressing relational patterns and dynamics outside of the clinical office. I am very sensitive to developmental factors that impact how a person may be presenting.

While goals for therapy differ from case to case, some reasons people seek therapy include:

- To care for any person affected by early trauma (abuse, physical, sexual, emotional, spiritual)
- Grief and loss
- To repair troubled relationships
- To improve communication, problem-solving, and coping skills
- To address child behavioral issues
- To manage family and parenting issues

Initial Contact:
The first appointment is a time for you to discuss your concerns and the problem from your point of view. It is a time to discuss a plan for therapy. It is a time to establish rapport and the clinical relationship is built upon this mutual connection. I ask that you complete this form prior to our first appointment to ensure I have all the relevant information to properly assess and establish goals together.

Children and Treatment Consent:
To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, my services fall under this, and you may be in violation of a court order if you fail to inform the other parent of my services with your child/adolescent. By signing this form you are stating that you have the legal right to consent for this child _____ (Please initial).

Confidentiality & Patients' Rights:
Confidentiality is your expectation that the information you disclose to Ms. Nix will be kept private, including the fact that you consult with her at all. Please note that Ms. Nix does discuss cases in peer supervision (though identifying patient information is not disclosed). By signing this consent to treatment, you give permission for these discussions when consultation is to aid Ms. Nix in providing effective therapy. All peer supervision consultations abide by the same ethical guidelines pertaining to mental health professionals and are bound by the same parameters of client privacy and confidentiality to maintain client confidentiality. As a general rule, outside of peer supervision, clinical information is not disclosed unless otherwise consented by authorized and signed document regarding other disclosures as a means to protect your privacy. One exception to this is if she employs outside services to collect past due accounts; by signing this form you give permission for such disclosure if necessary. There are also legal exceptions to confidentiality; these are described in the attached Notice of Privacy Practices, The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations (See HIPAA handout). The law requires she obtain your signature acknowledging she has provided you with this information; by signing below you are certifying that you have been given a copy of the Notice. You may revoke this Agreement in writing and that will be binding on her unless: she has taken action in reliance on it; if there are obligations imposed on Ms. Nix by your health insurer in order to process or substantiate claims; or if you have not satisfied any financial obligations. Please understand that all files are kept confidential. Your written consent is required for any release of information. There are important exceptions to confidentiality that are legally mandated. Exceptions include: (1) If Ms. Nix believes there is elevated risk that you/client intends to harm himself or someone else; (2) if there is suspected child abuse, elder abuse, or neglect; and, (3) if subpoenaed and ordered to share confidential information. In addition, when the client is a child in the custody of DSS or when DSS is conducting an investigation, DSS and the Guardian Ad Litem Program have the legal authority to access any confidential records related to the child.

Phone Messages:
Often, you will get my voicemail when you call as I am frequently in session during the day. Please leave a message and I will return your call as promptly as I am able. However, if you call with an emergency, my response time will reflect the urgency of the call to the best of my ability. ***If there is immediate or imminent risk for you or someone you know, it is your responsibility to call your local emergency room or 911 for medical professionals to evaluate the person in crisis thoroughly and promptly.*** If you leave a message to cancel an appointment, Ms. Nix trusts you will call back when you are ready to reschedule.

Ending Therapy:
Ending therapy may occur at any time and be indicated by either the client or the therapist. If you are unhappy with therapy, please share your concerns and perhaps changes can be made to make therapy more helpful to you. It is not unusual for an individual to meet with more than one therapist before they

find the "best fit." Please share your preferences, and Ms. Nix may be able to help you find a therapist who may be a better match for you. Typically, therapy ends when you have accomplished the goals you established at the beginning of therapy. If you stop attending sessions, Ms. Nix generally does not call out of respect for your choice. If you decide at a later date that you are ready to become involved in therapy again, please feel free to call her and ask to resume therapy. I understand that sometimes other circumstances need priorities and trusts you to call when you are again ready to prioritize therapy.

Sometimes unexpected life events happen causing people to take an unanticipated break from therapy. Patients are expected to communicate with me directly. I appreciate there are times when this notification is not given for various and unexpected reasons. Please note: ***clients who fail to attend therapy for 2 months without a clear acknowledgement to Ms. Nix to end services, will, by default, end the clinical privileges of a client- therapist relationship*** _____ (Please initial)**.** In other words, you will no longer be under my clinical care and legally cannot cite or in any way claim you are receiving treatment by Ms. Nix, LCPC. The clinical relationship is not necessarily forfeited, however privileges afford to active members will be excluded. If you would like to come back for services at a later date, please contact me and we can schedule a session. However, I leave the initiation of resuming therapy services in your hands as an indication of my trust in your ability to listen to and respond responsibly to your needs. In my experience, the above scenario is not typical. However, due to potential liability, it is necessary to document your consent and understanding that I cannot be referenced as your therapist if you are not in regular attendance.

Rates:

Given the vast changes in health coverage, differing deductibles and coverage among insurance plans, and in order to keep expenses to a minimum, my policy requires ***that clients make a full payment for services rendered at the time time of your appointment.*** I accept payment in cash, personal checks, Quick Pay and when necessary, a credit card may be charged. All payments can be made out to "Ms. Abi Nix, LCPC" at time of service. This ensures the therapist is paid in full for services rendered as insurance benefits vary and are often unknown at the time of intake.

Payment is expected at the time of service. You will receive a receipt documenting the service provided and payment rendered at the time of service. Initial diagnostic assessment is $225. Individual and family therapy (i.e. bringing one family member with you) is $175 per session. Family therapy sessions (more than one family member) are $185 per clinical hour.

Therapy sessions are by appointment only. One clinical hour is considered 55 minutes in session allowing for 5 minutes to document services. It is important to our clinical work that therapy is attended regularly.

Cancelation Policy:

There is a charge of $160 for missed appointments and appointments canceled for non-emergencies when notice is given with less than 48 hours. _____ (Please initial)

However, no charge will be made if: (1) you are ill, (2) you have an emergency, or (3) driving conditions are hazardous due to inclement weather. All other services, including phone calls, letters, telephone consultation, meetings attended on your behalf and at your request (including travel time) are billed at the same hourly rate. To avoid fees, please call or Email me 48 hours in advance.

Important Insurance Information:

As a therapist, my relationship is with you and not your insurance company. As such, all charges incurred are your responsibility. It is always best to address questions related to your coverage directly with your insurance provider as plans differ. Some insurance cards read that mental health services are

"covered." This can be misleading as it does not necessarily indicate your sessions are covered at 100%.

A receipt will be provided for all sessions at the time of service. Upon request, an invoice summarizing services can be provided at the end of each month for your records and can be submitted for insurance reimbursement purposes.

Please note in some cases, (i.e. students) may request that Ms. Nix submit insurance claims on their behalf. IF agreed by Ms. Nix, a current copy of your insurance card, your signature and date are necessary in order comply with Insurance and HIPAA policies.

Late Fees and Returned Checks:

The returned Check fee is $30. For therapy, if you do not pay in full on the date services are rendered and no prior arrangements were made, 10% of the original charge will be added each week you are late. Regarding delinquent accounts, you are responsible for full payment and will be charged in full any and all time we spend trying to collect on the account (billed at $160/hour), and/or any and all fees of any outside services, such as an attorney or credit collector, hired to collect the debt.

Testifying:

Participating in court for custody or any other matter is not an expected service. If you are seeking therapy in any way related to a legal matter (current or anticipated), this may not be the best fit. Instead, inform Ms. Nix immediately and she will do her best to refer you to an appropriate professional. Should Ms. Nix be subpoenaed, the rate is $700 per hour for all time related to responding to the subpoena regardless of whether she is called to testify. This may include time reviewing notes and talking with attorneys, as well as any phone calls or letters written on your behalf. If required to appear in court, she must cancel all other clients for that day, even when she is on "stand-by" status. You will be charged for the entire day. The rate is the same for depositions of fact or expert witness, as well as testimony.

Consent for Therapy:

Please sign below to indicate that you have read the preceding information in full and understand the information. Please ask for clarification of any information you are unclear about. Your signature indicates that you have read this document & agree to its terms in its entirety throughout our professional relationship.

I have also read and understand the policies and agree to the conditions. I agree to the statements herein and terms of payment, to include payment of all fees listed. I was offered a copy of these documents. If minor patient, I certify that I have the legal right to consent to treatment. Further, I acknowledge receipt of HIPAA Notice of Privacy Practices.

_____ _____

Signature Date