Cheryl D. Mikeska MA. LPC
Licensed Professional Counselor
1716 Briarcrest Dr. Suite 602
Bryan, TX 77802

PLEASE READ THIS PAGE FIRST (and retain for your records).

Dear Client,

Thank you for choosing Cheryl D. Mikeska as your therapist! I have been a Licensed Professional Counselor since 1994, and consider my work a true privilege and joy.

I would like to explain my philosophy of treatment and present two types of Counseling options. The first option is a Traditional Clinical approach, incorporating Cognitive and Behavioral techniques. These techniques are useful for the understanding of and possible change in human behavior and emotion. However, these techniques have limitations since they are based on Man's ideas and Man's ability to change oneself.

The second option is Biblically Based Counseling. While this option might use information from Clinical theories, it looks to the Word of God as the source of truth for the issue of discussion. It is my belief that God and His word offer true healing for the human heart, and for any issue of concerns.

Please complete the following pages, including the Intake Form and two HIPPA forms. You will notice one of the HIPPA forms is marked "Office Copy" and the other is marked "Client Copy". Please retain the copy marked "Client Copy" for your personal records. Also, please be sure to read the cancellation policy and the Personal Agreements section.

Prior to commencing our session, in the event that you have not completed the entire packet, it is necessary for you to sign the "Personal Agreements" as well as the HIPPA form before session can begin.

Lastly, please silence your cell phone and other electronic devices while we are in session. Thank you!

It is my hope that our time together will be blessed!

Sincerely,

Cheryl Mikeska MA. LPC

Phone 979-777-6506 Fax 979-268-0207 www.cherylmikeskalpccounselingcenter.com

CHERYL MIKESKA, MA. LPC

INTAKE FORM

Note: This information is confidential Today's Date _____

Demographic Information:

Name: Date of Birth: Age:

Home Mailing Address: Relationship Status: S M D W

City, State, and Zip Military? Y or N College Student: Y or N

College/Univ Name: Yr in college 1 2 3 4 Bachelor; Masters; PhD, other?

Best Contact Phone #: Message Ok? Y / N Text Ok? Y / N

Email: Is it ok to email you? Y / N

Current Employer: Position/Title:

Current Occupational Status: F/T, P/T, Self Employed

Emergency Contact Name:

Emergency Contact Relationship: Emergency Contact Phone:

Were you referred? If Referred, by Whom?:

Purpose for/of Seeking Counseling:

Current Concerns:

What concern/s brings you to counseling today?

When did this/these concern/s begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern.

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

Last Name _____

Current Concerns Continued:

Are there any obstacles that could get in the way of accomplishing your goals for counseling? If so, what are they?

Have you had prior therapy or counseling? Or have you received any prior professional assistance for your concerns? If so, please provide name and location of counselor/therapist/psychiatrist and year/s of sessions.

Spiritual History:

Spiritual Foundation: Christian Jewish Other Denominational Affiliation: _____
(i.e., Catholic, Lutheran, Baptist)

Is spirituality important to you? Y or N How often do you pray? daily occasionally seldom

Please share if there is anything in your spirituality that you want to specifically focus on or bring into your counseling sessions?:

_____

_____

Family Systems Information:

Birthplace: Ethnic ID:

# of Marriages for you: Current Spouse's Name:

If not married, significant other? Y N Significant Other's Name:

Do you have Children: Y N If so, please list names and ages:

Family history of alcoholism? Y N Family history of sexual addiction or abuse? Y N

Mother alive? Y N Relationship: excellent good fair poor n/a

If deceased, your age at time of death:

Father alive? Y N Relationship: excellent good fair poor n/a

If deceased, your age at time of death:

Parents Divorced? Y N If yes, your age at time of divorce:

Siblings? Y N If yes, names and ages:

_____

Birth Order Placement: Oldest Youngest Middle Only Child Other

Any Step Parents? Relationship: excellent good fair poor n/a

Were you adopted?: Y N Were you raised by someone other than your parents?: Y N

If yes, who raised you and why?:

Anything else that you think would be helpful for me, as your Therapist to know?

Last Name _____

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal Attempts	Can't keep a job	Take drugs- illegal	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of Motivation	Drink Too Much	Nervous Tics	Eating Problems
Work Too Hard	Procrastination	Sleep Disturbance	Phobic Avoidance	Impulsive Reactions
Crying	Outbursts of Temper	Loss Of Control	Aggressive Behavior	Concentration Difficulties

Are there any specific behaviors, actions, habits that you would like to change?: Y or N if Yes, please identify:

_____

_____

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Arduous	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Apathetic	Others:

Are there any specific feelings that you would like to change or address?: Y or N if Yes, please identify:

_____

_____

Physical - circle any of the following symptoms that apply to you:

Headaches	Stomach Trouble	Skin Problems	Dizziness	Tics
Dry Mouth	Palpitations	Fatigue	Burning/Itchy Skin	Muscle Spasms
Twitches	Chest Pains	Tension	Back Pain	Rapid Heart Beat
Sexual Disturbances	Tremors	Unable to Relax	Fainting Spells	Blackouts
Bowel Disturbances	Hear Things	Excessive Sweating	Tingling	Watery Eyes
Visual Disturbances	Numbness	Flushes	Hearing Problems	Don't like being touched

Biological Factors:

Do you have any current concerns about your physical health? If so, please specify:

Please list medications you are currently taking, or have taken during the past 6 months on the following "Medication List Form". (include any medications that were prescribed or taken over the counter – herbs, homeopathic, vitamins, etc).

Do you get regular exercise? If so, what type and how often?

Last Name_____

Check any of the following that apply to you:

N = Never R = Rarely F = Frequently VO = Very Often

	N	R	F	VO		N	R	F	VO		N	R	F	VO
Marijuana					Heart Problems					Stimulants				
Tranquilizers					Nausea					Hallucinogen				
Sedatives					Vomiting					Diarrhea				
Aspirin					Insomnia					Lack of Interest				
Cocaine					Headaches					Alcohol				
Pain Killers					Backaches					Laxatives				
High Blood Pressure					Early Morning Awakening					Compulsive Exercise				
Coffee					Fitful Sleep					Constipation				
Cigarettes					Bing/Purge					Allergies				
Narcotics					Poor Appetite					Junk Foods				

Statement of Understanding Regarding Mandated Reporting:

As a mandated reporter, Cheryl Mikeska is required to report any past or present disclosures of abuse or neglect. Our intent is to be helpful during this process, but we also want to make our clients aware of the potential for that sensitive information to be reported. If a client reveals that he or she has been the victim of abuse or neglect, it will be reported to the proper authorities.

If you have any questions about what that process could entail, please feel free to ask Cheryl.

_____

Signature Date

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers:_____This is your ACE Score.

092406RA4CR

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ ***(please estimate if you are not sure)***

Did it involve actual or threatened death, serious injury, or sexual violence?

_____Yes

_____No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____Accident or violence

_____Natural causes

_____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This office abides by all of the policies and practices required by HIPAA. This form is a "friendly" version. A more complete text is located in the office.

What this is all about: specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient/client. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov.

1. Patient/Client information will be kept confidential except as necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information as is necessary and appropriate for your care. Patient/Client files may be stored in open file racks and will not contain any coding which identifies a patient's/client's condition or information which is not already a matter of public record. You agree to the normal procedures utilized within the office for the handling of charts, patient/client records, PHI, and other documents or information.
2. It is the policy of this office to remind patients/clients of their appointments. We may do this by telephone, email, text, U.S. mail, or by any means convenient for this office and/or as requested/approved by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the Counselor.
5. Your confidential information will not be used for the purposes of marketing or advertising products, goods, or services.
6. We agree to provide patients/clients with access to their records in accordance with state and federal laws.
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the office and the client.
8. You have the right to request restrictions in the use of your protected health information, and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the
(Please print name)

terms set forth in the HIPAA INFORMATION FORM and any subsequent change in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Client Signature Date

HIPAA Information and Consent Form

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Cheryl D. Mikeska, LPC, has adopted the following policies:

1. Patient/Client information will be kept confidential except as necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information as is necessary and appropriate for your care. Patient/Client files may be stored in open file racks and will not contain any coding which identifies a patient's/client's condition or information which is not already a matter of public record. You agree to the normal procedures utilized within the office for the handling of charts, patient/client records, PHI, and other documents or information.
2. It is the policy of this office to remind patients/clients of their appointments. We may do this by telephone, email, text, U.S. mail, or by any means convenient for this office and/or as requested/approved by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the Counselor.
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(Please print name)

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_____ _____

Client Signature Date

Cheryl D. Mikeska MA. LPC
Licensed Professional Counselor
1716 Briarcrest Dr. Suite 602
Bryan, TX 77802

Personal Agreements:

I understand that I may be asked to do certain "homework exercises" such as reading, praying, changing my behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward ***even if it is painful and difficult.***

I understand that what I say in a session is **strictly confidential** and will not be released to anyone without my consent, unless I am violating codes of abuse, harm to myself, or harm to others.

I understand that **I will pay my co-pay in full at or before each appointment.** I also give Cheryl D. Mikeska permission to bill my insurance carrier directly.

_____

Client Signature & Date

The cash price for each 55 minute session is $110 dollars that needs to be paid in full prior to each session. Sessions that continue longer than one hour will be charged in 15 minute increments.

_____

Client Signature & Date

It is my preference (as indicated below with an X), to choose the following counseling option:

Traditional Counseling **ONLY** _____

Biblical Counseling **ONLY** _____

A **combination** of both traditional and biblical counseling _____

_____

Client Signature & Date
(If client is under 18, must be signed by responsible adult/party)

As your counselor, you honor me by sharing your life and growth with me. I will have high regard for you as a person and will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance, so help me God. You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person and as a child of God, in need of care. I will do my best to honor that. If you ever have questions about my views, or if you are unclear about them, then please advocate for yourself by letting me know.

Cheryl D. Mikeska MA. LPC
Licensed Professional Counselor
1716 Briarcrest Dr. Suite 602
Bryan, TX 77802

Cancellation/No Show Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please text Cheryl Mikeska as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please text 979.777.6506 between the hours of 8 am – 5 pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24 hours before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a $75 dollar missed appointment fee.

For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee ($110 dollars).

_____ _____

Patient Name Print Date

_____

Patient Name Signature

Phone 979-777-6506 Fax 979-268-0207 www.cherylmikeskalpccounselingcenter.com

Medication List

Name:_____

Are you currently taking any medication or you have previously? Yes No

If yes, please list the medications below:

Name of Medication	Date Added	Date Stopped