# Woodlands Family Institute, P.C.

Ali M. Lichty M.A., LPC, RHC
Licensed Professional Counselor

## Information, Consent, and Policies

We are honored that you have selected the Woodlands Family Institute to provide counseling or psychological services. All of us wish to do our best to assist you in making this experience meaningful and fruitful as possible. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I currently hold a Bachelor's Degree in Psychology from the University of Texas at Austin, Master's Degree in Counseling Psychology from the University of Denver, and am a Licensed Professional Counselor in the state of Texas. My formal education has prepared me to counsel individuals, groups, couples/families, adolescents, and children. Additionally, I am a member of the Houston LPC Association and the American Counseling Association.

I believe that no matter how difficult a person's circumstances may be, it is possible to produce meaningful change. I view the therapeutic relationship as a collaboration with my client on a unique journey towards self-enhancement, wellness, and goal attainment. Sometimes this takes a long time to achieve. While some clients need only a few sessions to reach their goals, others may require months or longer. This is truly an individual quest. As a client, you are in complete control and may end our professional relationship at any point. I will be supportive of that decision. Ultimately, my job is to work myself out of a job, so that you feel confident to carry on without my intervention.

This process is a partnership between you and me to work on areas of dissatisfaction in your life or to assist you with life goals. For this to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, being forthright about your issues and goals, and openly discussing the process with me. Therapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. While counseling or psychotherapy can benefit most people, the process is not always helpful. Sessions can evoke strong emotions and sometimes influence unanticipated changes in one's behavior. It is important that you discuss with me any questions or discomfort you may have during the process. I may be able to help you understand the experience or use a different approach that may be more satisfying.

I assure you that our work will be conducted in a conscientious manner consistent with accepted ethical standards. Please note that it is not possible to guarantee any specific results regarding your goals. However, together we will work to achieve the best possible results.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you arrange with me. It may be confusing and counter-productive for me to accept gifts or be invited to social gatherings. So please do not ask me to relate to you in any way other than in the professional context of our sessions. I want your sessions to be safe and secure as possible so that we concentrate exclusively on your concerns. You are best served by experiencing me in my professional role.

Please be aware that I **do not** provide consultation, evaluation, or legal testimony in child custody, child visitation, or molestation cases. If you require these services, I will be happy to refer you to professionals who work with these issues.

Children can be joyful and energetic, but with respect to the concerns which brought you to us, we request that you obtain a sitter for children not receiving treatment so that our full attention can be devoted to your priorities.

## Office Policies

### FEE SCHEDULE

**Standard rate:** $150.00 per standard 50 minute session. Cash or personal checks are accepted. Charges for other professional services are prorated on the bases of $150 per hour, 15 minute increments. These services include, but are not limited to, phone calls, insurance reports, third-party consultations, and correspondence. Off-site consultation is charged at the rate of $150 per hour, "portal to portal", that is, for the time I am out of the office on your behalf.

Please be advised that I **do not** provide consultation, evaluation or legal expert testimony in child custody, child visitation or molestation cases. Similarly, I do not consider my practice to include expert testimonials. However, should my opinion be so ordered, fees will be charged at the rate of $500.00 per hour, portal to portal. This fee will apply as well to depositions or interrogatories. All fees of this nature are **payable in advance**.

**Payment Policy:** Payment is due in full at time of service. Please make out your check before the session begins. Checks should be made out to: Woodlands Family Institute (or WFI). Cash and Visa or MasterCard are also accepted. It is not my policy to carry balances forward. I expect balances for "forgotten checkbooks" or forgotten appointments to be made up promptly or by the next scheduled appointment at the latest. Follow-up appointments will not be honored if your account is overdue. If an outstanding balance accrues, you will be billed on the first of the month assessed a 2% finance charge, compounded monthly. There is $10.00 rebilling fee for every statement sent out after the first billing. There is also a $25.00 fee for each check returned for insufficient funds. After 90 days with no payments or effort to arrange payment, accounts will be turned over to a collection agency and will impact your credit rating.

**______ Initials indicating you understand payment policy and fees**

### INSURANCE

I am not in any insurance networks. We will provide you with an insurance-ready receipt that you can use to file for out of network benefits. Reimbursement will depend on your insurance plan. Your health insurance policy is a contract between you and your insurance company. I am not a party to that contract. We advise that you contact a company representative to determine how your insurance company will reimburse you. Some insurance companies reimburse clients for services, and some do not. Those that do usually require a standard amount be paid by you before reimbursement is allowed, and then usually a percentage of the fee is reimbursable. The client remains responsible for payment in full, including any portion not reimbursed by insurance. **Please be aware that: Third-party payers require the provision of a diagnosis and supporting clinical data. We have no control over the confidentiality procedure of third parties once clinical information leaves this office. In all likelihood, a computer record will be generated.**

Since I do not contract directly with insurance companies, I am responsible and accountable only to you. Thus my loyalties are not divided, and there is no conflict of interest.

### OFFICE HOURS

Monday through Friday, 9:00am-7:00pm. Friday, the office staff is available 8:00am-5:00pm. Any hours beyond stated office hours (Mon-Fri.) are considered as "after hours," and will be charged accordingly. After hours time is generally reserved for family time and self-care.

**CANCELLATIONS**

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours' notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for
missed sessions without such notification. Please call the office to cancel an appointment. E-mail is not monitored for cancellations. *Please note that insurance companies do not reimburse for missed appointments.*

**_____ Initials indicating you understand the cancellation policy**

**EMERGENCIES**

It is assumed that outpatient clients are self-responsible, autonomous, and not in need of day-to-day supervision. Outpatient clinicians cannot assume responsibilities for clients' day-to-day functioning, as can agencies or inpatient hospital settings. Nevertheless, in the event that a true emergency arises, please contact our answering service at (713) 866-4494 or (281) 363-4220, inform the operator that you have an emergency, and request that your therapist be contacted immediately. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. If we are unable to respond quickly enough, you are encouraged to call the Houston Crisis Line at (832) 416- 1177, The National Suicide Prevention Lifeline at 1 (800) 273-8255, 911, or go to your nearest emergency room.

**CONFIDENTIALITY**

The law protects the privacy of all communications between a client and psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by federal and state law. There are other situations that require only that you provide written, advance general consent. Your signature on our Acknowledgment form provides consent for those activities, as follows:

You should be aware that we practice with other mental health professionals and utilize administrative staff. In most cases, some protected information must be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Occasionally, it is helpful to consult other health and mental health professionals about a client. During a consultation, every effort is made to avoid revealing a client's identity. Any other professionals consulted are also legally bound to keep the information confidential. These consultations are very commonplace and routine and may not ordinarily be mentioned in our sessions unless it seems important to our work together. If you would prefer to handle this differently, please let us know. All administrative staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

All information disclosed within sessions is confidential and may be revealed only in certain situations. At times I may legally and/or ethically be required to share information about you without your consent. Such situations are, but are not limited to the following: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court or regulatory body to disclose information; d) you disclose or there is reasonable suspicion of abuse or neglect of children, the elderly, or disable persons; e) the need to release information to other professionals involved in your treatment; f) in proceedings in which a claim is made about one's physical, emotional, or mental condition; g) when disclosure is relevant in any suit affecting the parent-child relationship; h) in legal or regulatory actions against a professional; i) where otherwise legally required. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to third parties.

Having read the policies described above, I agree to all professional policies, agree to meet all financial obligations, and agree that this contract replaces any earlier contracts. Additionally, I understand that there can be no absolute guarantee of cure in the practice of psychotherapy.

_______________________________________________  _________________________

**Signature** **Date**

## Client Information Statement

The Texas Boards of Examiners of Licensed Psychologists, Marriage and Family Therapists, Licensed Social Workers and Licensed Professional Counselors were established by the legislature to protect the public. In fulfilling its mission, the Boards enacted rules governing the practice of psychology, family therapy, and counseling. These rules require that a therapist provide prospective clients with sufficient information about the therapeutic process so that the client can make an informed decision whether or not to enter therapy.

Attached to this Information Statement is a general information statement, Agreement for Services and the information regarding the procedures or psychotherapy in general and our office policies.

**After reading the agreements, please ask about any part of the agreement that you do not understand.**

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## PERSONAL DATA RECORD

**Client Name** ____________________________ Date of Birth __________________

Address _______________________________________________________________

City/State/Zip _________________________________________________________

SSN ________________________________ TXDL _______________________

Employer/School/Address __________________________________________________

**May we leave a message at any of the following?**

Cell phone (circle one) ___________________________ Yes No

Work phone (circle one) ___________________________ Yes No

Unencrypted email address ___________________________ Yes No

*** Please do not cancel appointments via email. You must contact the office directly.**

If you would like to use an address other than your home address for billing and other correspondence, please provide an alternative address below.

Other __________________________________________________________________

***CONSENT FOR TREATMENT***

Client Name _____________________________________ Date of Birth ________________

I give full consent for ***myself, my child/adolescent or dependent*** due to legal guardianship to receive outpatient mental health services until I notify WFI of any changes or until it is determined the treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for the individual stated above.

_______________________________________________ _________________

Authorized Signature Date

**REQUIRED: We require that a credit card be provided for after-hours appointments, missed sessions, and late cancellations. You may also designate the use of this card for regularly scheduled sessions.**

Cardholder's Name____________________________________ Relationship_____________

MC/VISA/DISC No.______________________________ Exp. Date _______________

Signature of Authorized User ________________________________________________

☐ **Use for regular sessions, after hours, missed or late cancel sessions**

**Financial Responsibility**

Name of person(s) financially responsible for this account ___________________________

Address/phone if different from client ____________________________________________

______________________________________________________________________________

______________________________________________________________________________

Signature(s) __________________________________________________________________

Relationship to client __________________________________________________________

**Emergency Contact**

Name ________________________________ Phone _________________________

Alternate phone ________________________ Address________________________

______________________________________________________________________________

Relationship to client __________________________________________________________

**Referred** to our office by ______________________________________________________

May we send a **thank you** to the person who referred you? (circle one) Yes No

May we mention your **name** in that thank you? (circle one) Yes No

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## Appointment Reminders

As a courtesy, you will receive an appointment reminder to your email address or your cell phone (via text message or computer generated voice mail message), the day before your scheduled appointments.

Your name: (Please print): ___________________________________________________

Your email address: ______________________________________________________

Your cell number: ________________________________________________________

Where would you like to receive appointment reminders? (Check one)

_____ Via text message on my cell phone (normal text message rates will apply)

_____ Via email message to the address listed above

_____Via automated voice mail message on my cell phone

****Missed appointment fees will still apply. 24 hour cancellation policy still applies. Please call the office if you need to cancel an appointment.****

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 noted above.

_________________________________________ _____________________
Signature Date

**{Please refer to pages 8-9 of this document}**

I acknowledge that I have been provided a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Office Information and Office Policies.** I understand and accept those policies and practices. WFI is hereby granted consent to contact me as specified above and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations.

__________________________________________________ ___________
Client or Authorized Representative Signature Date

_____Refuse to Sign _____Unable to Sign (specify reason) _____________________

___________________________________________________ ___________
Signature of Person Documenting Refusal or Inability to Sign Date

## Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Woodlands Family Institute (WFI) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *general consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a colleague.
  *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within WFI such as utilizing information that identifies you.
- "*Disclosure*" applies to activities outside of WFI, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation regarding a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Abuse of the Elderly and Disabled:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.
- **Sexual Misconduct by a therapist:** If you report to us any situation that constitutes sexual misconduct by a current or former therapist, then we are required to inform the licensing authority of the offending therapist.
- **Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case**.**
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

**IV. Client's Rights and Our Professional Duties**

Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeking our services. Upon your request, we will send bills or other correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Our Professional Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a current copy in our offices. A current copy will always be available on our web site and you may request a personal copy.

**V. Questions and Complaints**

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Mary Piehl, Office Manager, or your therapist at (281) 363-4220.

If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint to Mary Piehl or your therapist at: 1610 Woodstead Ct., Suite 420, The Woodlands, TX 77380.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

**VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on 3/28/2005. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in our lobby and on our web site. You may request a personal copy at any time.

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## PSYCHOSOCIAL HISTORY

Client Name: ______________________________ Date: ______________

Gender: Female Male Date of Birth: ________________ Age: ______________

Disability status: ________________________________ Talk about later

Gender identity: ________________________________ Talk about later

Sexual orientation: ________________________________ Talk about later

Racial/ethnic identities: ________________________________ Talk about later

Religious/spiritual traditions or identity: ______________________ Talk about later

Other ways you identify yourself and consider important: ______________________

### Presenting Problem(s)

Primary reason(s) for seeking services, check all that apply:

| | | | |
|---|---|---|---|
| Abuse(verbal/emotional/sexual) | Coping | History of trauma | Relationship Issues |
| Addictive behaviors | Depression | Mental confusion | Sexual concerns |
| Alcohol/drugs | Eating disorder | Neglect/abandonment | Sleeping problems |
| Anger management | Fear/phobias | Recent life transition | Stress |
| Anxiety | Gender identity issues | | |

Other mental health concerns (specify): ______________________________

Please describe the main difficulties that led to you coming to see me: ______________________

________________________________________________

________________________________________________

When did these problems start? ______________________________

What makes these problems worse? ______________________________

________________________________________________

What makes these problems better? ______________________________

________________________________________________

With therapy, how long do you think it will take for these to get a lot better? ______________

How do you generally cope with life stressors or other problems? ______________________

________________________________________________

What are your goals for therapy? ______________________________

________________________________________________

________________________________________________

What do you believe are your strengths? ______________________________

________________________________________________

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Please check all behaviors and symptoms that occur to you more often than you would like them to take place:

| | | |
|---|---|---|
| Abandonment | Erratic behavior | Outbursts/rage |
| Alcohol abuse/dependence | Excessive worry | Parenting problem(s) |
| Agitation | Fatigue | Paranoid thoughts |
| Anger | Feeling of neglect | Phobias/fears |
| Antisocial behavior | Flat emotions | Physical aggression |
| Anxiety | Gambling | Poor concentration |
| Avoiding people | Hallucinations | Racing thoughts |
| Change in appetite | Heart palpitations | Recurring thoughts |
| Chest pain | High blood pressure | Relationship discord |
| Commits unlawful acts | Hopelessness | Sadness |
| Compulsive behavior | Homicidal ideations | Self-confidence |
| Cyber addiction | Hyperactive | Self-harm |
| Delusions | Impulsivity | Sexual addiction |
| Depression | Irritability | Sexual difficulties |
| Destruction of property | Isolation | Sick often |
| Difficulty with authority | Judgment errors | Sleeping problems |
| Difficulty making friends | Lack of energy | Social isolation |
| Difficulty at school/work | Lack of guilt for wrongdoing | Speech problems |
| Disorientation | Lack of motivation | Suicidal thoughts |
| Dizziness | Loneliness | Tearful |
| Drug abuse/dependence | Low self-esteem | Thoughts disorganized |
| Easily distracted | Memory impairment | Trembling |
| Eating disorder | Mood swings | Weight loss/gain |
| Elevated mood | Obsessive thoughts/behaviors | Withdrawing |

Other (specify): ____________________________________________

Briefly discuss how the above symptoms impair your ability to function effectively: ______________________

____________________________________________

____________________________________________

## Psychiatric History

Have you ever had thoughts about wanting to hurt yourself or end your life? No Yes. If yes, please describe (when, plan, action, etc.): ____________________________________________

____________________________________________

____________________________________________

Are you currently experiencing any thoughts of suicide or self-harm? No Yes. If yes, please describe (plan, action, how often, etc): ____________________________________________

____________________________________________

____________________________________________

Have you ever had thoughts about wanting to hurt or end someone else's life? No Yes. If yes, please describe (when, plan, who, action, etc.): ______________________________

______________________________

Are you currently experiencing any thoughts of homicide or harming someone else? No Yes. If yes, please describe (when, plan, who, action, etc.): ______________________________

______________________________

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatment, medications, or counseling services before?No Yes. If yes, please describe:

| When (dates)? | For what (diagnosis)? | What kind of treatment? | Where or from whom? | Outcome |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you ever been a part of a support group for your mental/behavioral health (i.e. Alcoholics Anonymous, Overeaters Anonymous, Al-Anon, self-help groups, etc.)? No Yes. If yes, please describe (group, dates, experience, etc.): ______________________________

______________________________

## Medical/Physical Health

List any current health concerns, please include any chronic conditions/illnesses: ______________________________

______________________________

List any significant past health concerns: ______________________________

______________________________

List out any history of surgeries, please include dates, age at time of surgery, and any side effects: ______________

______________________________

Have you ever been hospitalized for any significant period of time (overnight)? If yes, when, why, and for how long?

______________________________

______________________________

Please check if there have been any recent changes in the following:

Sleep patterns Eating patterns Behavior Energy level
Physical activity level General disposition Weight Tension

Describe changes in areas in which you checked above: ______________________________

On average, how many hours of sleep do you get in a night? ______________________________

Activity level: Sedentary Light Moderate Active Athlete

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Please list out any prescribed or over-the-counter medications you are currently taking, including herbs, vitamins, and/or supplements.

| Name of medication | Dosage | Dates | For what condition? | Prescribed & supervised by: | Outcome or side effects |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Marital/Relationship Status

Check all that apply:

| Status | Dates | Length of Time |
|---|---|---|
| Single | | |
| Legally married | | |
| Divorced | | |
| Separated | | |
| Divorce in process | | |
| Widowed | | |
| Annulment | | |
| In a committed relationship | | |
| Unmarried, living together | | |

Assessment of current relationship (if applicable): Good Fair Poor

Total number of marriages and when: ______________________________

## Family History

List out any family history of major medical health problems, drug or alcohol use, and mental or emotional difficulties: ______________________________

______________________________

______________________________

______________________________

Who were you raised by? ______________________________

How were you disciplined as a child? ______________________________

______________________________

Please provide information about your family, including current/past spouses, significant others, children, parents, step families, adoption history, etc.

| **Name** | **Relationship** | **Living? Yes or No** | **Age** (if deceased, age at death) | **Living where?** |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |

Please describe your parents', stepparents', or guardians' relationship(s) with each other:

______________________________________________________________________________

______________________________________________________________________________

What is your relationship with each parent and with any other adults present when you were growing up:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What is your relationship with your brothers and sisters (or stepsiblings), in the past and present:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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Has any relative had inpatient or outpatient treatment for a psychiatric, emotional, or substance use disorder? No Yes. If yes, please describe:

| Name/relationship | For what (diagnosis)? | What kind of treatment? Where or from whom? | When (dates)? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Traumatizing Life Events

Have you experienced any history of significant abuse (physical, emotional, verbal, or sexual)? If yes, please describe:

_______________________________________________________________________________

_______________________________________________________________________________

Describe any history of significant life events such as deaths, separation from parent(s), neglect, frequent moves, terminal, inadequate nutrition, illnesses in the family or close friendship? ___________________________

_______________________________________________________________________________

_______________________________________________________________________________

## Drug and Alcohol Abuse

| | Method of use & amount | Frequency of use | Age of first use | Check if yes for any of the following: | | |
|---|---|---|---|---|---|---|
| | | | | **Used in last 48 hours?** | **Used in last 30 days?** | **Used in last 10 years?** |
| Alcohol | | | | | | |
| Barbiturates | | | | | | |
| Valium/Librium | | | | | | |
| Cocaine/Crack | | | | | | |
| Heroin/Opiates | | | | | | |
| Marijuana | | | | | | |
| PCP/LSD/Mescaline | | | | | | |
| Inhalants | | | | | | |
| Caffeine | | | | | | |
| Nicotine | | | | | | |
| Over-the-counter | | | | | | |
| Prescription drugs | | | | | | |
| Other | | | | | | |

Preferred substances: _________________________________________________________________

When and where do you typically use substances? ___________________________________________

Reason(s) for substance use (check all that apply):

Addicted | Build confidence | Escape | Self-medication
Socialization | Taste | Other (specify):________________________

How do you believe your substance use affects your life? ____________________________________________

______________________________________________________________________________

Who or what has helped you in stopping or limiting your use? ________________________________________

Have you had adverse reactions or overdose to drugs or alcohol? (describe): No Yes. If yes, describe: _____

______________________________________________________________________________

Have drugs or alcohol created a problem for your job? No Yes. If yes, describe: ______________________

______________________________________________________________________________

Do you think that you have a drug or alcohol problem? No Yes

## Educational History

Fill in all that apply: Years of education: ________________ Currently enrolled in school? No Yes

Most recent school: ___________________________________________________ Grade: __________________

Highest degree earned: ___________________________________ Average grade performance: _____________

High School/GED: Number of years: ______ Graduated: Yes No

Vocational Training: Number of years: _____ Graduated: YesNo Major: _______________________

College: Number of years: _______________ Graduated: Yes No Major: _______________________

Graduate: Number of years: ______________ Graduated: Yes No Major: _______________________

## Employment History

Current occupation: ____________________________________________ Part-time Full-time Unemployed

Current employer: ______________________________________________ Date hired: ___________________

Position/Title: ______________________________________ Location: ______________________________

Positive/negative aspects of current position: ____________________________________________________

______________________________________________________________________________

Previous employment history:

| From (date) | To (date) | Name of employer | Job title or duties | Reason for leaving |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

# Woodlands Family Institute, P.C.

Ali M. Lichty M.A., LPC, RHC
Licensed Professional Counselor


## Military Experience

Military experience? No Yes Combat experience? No Yes. Where: ______________________

Branch: ________________________________ Date enlisted: ________________ Date drafted: ________________

Discharge date: ____________ Type of discharge: __________________ Rank at discharge: ________________

## Legal History

Are you involved in any active cases (traffic, civil, criminal)? No Yes. If yes, please describe and indicate the court and hearing/trial dates and charges: ________________________________________________________

________________________________________________________________________________________

Is your reason for coming to see me related to an accident or injury? No Yes. If yes, please explain: _______________

________________________________________________________________________________________

Are you presently on probation or parole? No Yes. If Yes, please describe: ___________________________________

________________________________________________________________________________________

Are you required by a court or probation/parole officer to have this appointment? NoYes

Past legal history (check all that apply): DWI, DUI, etc.Criminal Involvement Civil Involvement

If you responded Yes to any of the above, please fill in the following information.

| Charges | Date | City, State | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever declared bankruptcy? No Yes. If yes, when: ______________________________________

Have you had any other legal involvements? No Yes. If yes, please explain: __________________________

________________________________________________________________________________________

## Other

Check how you generally get along with other people (check all that apply):

Affectionate Aggressive Avoidant Fight/argue often Follower
Friendly Leader Outgoing Shy/withdrawn Submissive
Other (specify): ____________________________________________________________________________

Who is part of your support system and how are they supportive of you?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Are you experiencing any problems due to cultural or ethnic issues? No Yes. If yes, describe: __________

________________________________________________________________________________________

How important to you are spiritual matters? Not at all Little Moderate Very important

Are you affiliated with a spiritual or religious group? No Yes. If yes, describe: ______________________

______________________________________________________________________________

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? No Yes. If yes, please tell me about it here or on another sheet of paper: ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________ ______________________

**Client/Guardian Signature** **Date**

Woodlands Family Institute, P.C.
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## Treatment Plan

Client Name: ______________________________________________ DOB: _________________

**Diagnoses** (current best formulation): DSM-5 or ICD-10

| Code # | Name of Diagnosis |
|---|---|
| | |
| | |
| | |
| | |

Treatment goals: ________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Strategies/Interventions:

Individual Therapy: ____________ times a /week ___________/times a month
Family Therapy/Couples Counseling: ___________ times a /week ___________/times a month
CBT DBT ACT Supportive Active Listening Interpersonal
Psychoeducational Stress management Relaxation training
Other: ____________________________________________________________________________

___________________________________________________________________________

Referrals and/or recommendations for further treatment/evaluation:

___________________________________________________________________________________

___________________________________________________________________________________

Documents to be obtained: __________________________________________________________

___________________________________________________________________________________

Summary/Case conceptualization: _____________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

_____________________________________________________ ________________________
Ali Lichty, LPC #69413 Date

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