Information, Consent, and Policies

We are honored that you have selected 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. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a graduate with a Master of Arts in Clinical Mental Health Counseling from Sam Houston State University. I am licensed by the state of Texas as a Licensed Professional Counselor Associate and supervised by Pam Cosart, LPC-S (License #66526). My formal education has prepared me to counsel individuals, groups, couples, families, adolescents, and children. My expertise includes counseling children through play therapy, individuals (adolescents and adults), families, marriage, parenting issues, and group psychotherapy.

I hold an abiding belief that no matter how difficult a person's circumstances may be, it is possible to produce meaningful change. I view the therapeutic relationship as collaboration with my client on a unique journey towards self-enhancement, wellness, and goal attainment. I view most issues as a systemic issue and helping a client function well within their own family, work, and social system is a primary goal. For that reason, I prefer working on relationship issues with all parties involved. My theoretical basis takes into consideration the developmental stage of not only the individual but the family as well. In this effort, we explore the emotional and psychological demands of individuation, and interpersonal and adaptive coping skill development. 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. My expectations of my clients are to keep scheduled appointments, be forthright about issues and goals, and take an active and engaging role in the process.

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 as safe and secure as possible so that we can concentrate exclusively on your concerns. You are best served by experiencing me in my professional role.

If at any time you are dissatisfied with my services, please let me know. 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 effective for you. 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.

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.

We respectfully request that CELL PHONES be turned off during your sessions.

____ Initial:

Office hours: Monday through Friday, 9:00am-7:00pm. Friday, the office staff is available 8:00am-3:00pm. 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.

____ Initial:

Cancellations:

All cancellations are expected to be made with 24-hour's notice. If you cancel your scheduled appointment less than 24-hours, or if you are a "no show," you will be charged the **full rate of the session**. Please note that insurance companies do not reimburse for missed appointments. **Please call WFI at: 281-363-4220 for cancellations, as email is not monitored daily for cancellations.**

____ Initial:

Insurance: Your health insurance policy is a contract between you and your insurance company. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. 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. The office staff will provide you with insurance-ready receipts for filing your claim. WFI does not file out-of-network insurance claims.

____ Initial:

Confidentiality: 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:

- Information released to other professionals involved in your treatment.
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are determined to be in imminent danger of harming yourself or someone else unless protective measures are taken.
- If you disclose abuse or neglect of children, the elderly, or disabled person. In the instance of reasonable suspicion of child or elder abuse.
- If you disclose sexual misconduct by a therapist.
- To individuals, corporations or governmental agencies involved in paying or collecting fees for services (this includes insurance companies).

Please be advised that insurance reimbursement usually requires background information, including substance abuse, diagnostic criteria, and treatment plan form completion. In addition, please note that most applications for health insurance include a release of information for medical records (this would include therapy/counseling records).

- In criminal court proceedings.
- In legal or regulatory actions against a professional.
- In proceedings in which a claim is made about one's physical, emotional, or mental condition.
- When disclosure is relevant in any suit affecting the parent-child relationship. This includes divorce and child custody deliberations.
- Where otherwise legally required.

____ Initial:

Emergency services: 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, if an emergency occurs, leave a message with the answering service, making sure to state that your call is an emergency. We will respond to your call as promptly as possible. Routine calls will be returned during normal office hours. We can be reached at 281-363-4220 or 713-866-4494. If we are unable to respond quickly enough, please call 911 or your local emergency room.

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 a 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.

Referred to our office by _____

May we send a thank you to the person who referred you? ☐ Yes ☐ No

May we mention your name in that thank you? ☐ Yes ☐ No

CLIENT INFORMATION

First name: _____ Last name: _____

Age: _____ Birth Day: _____ Month: _____ Year: _____

Home address with postal code: _____

Cell #: _____ Home #: _____

Email:_____

Preferred method of contact:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Consent for treatment for clients 18 & older: I give full consent for myself to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Name of client: _____ Signature: _____ Date:_____

Consent for treatment for clients 17 & younger:

I give full consent for my child to receive outpatient mental health services in person, by telephone, or by remote video platforms until I notify WFI of any changes or until it is determined that treatment is no longer necessary. **For minors of parents who have an active custodial order/divorce decree in place: It is required by the Texas State Licensing board that a copy of the current custodial order/divorce decree be kept on file stating who has the authority for making mental health decisions for a minor. It will be necessary to provide this BEFORE your child's first session.**

Name of client: _____ Date of birth: _____

Name of parent/guardian:_____ Signature: _____ Date:_____

Name of parent/guardian:_____ Signature: _____ Date: _____

REQUIRED: We require that a credit card be kept on file for all sessions. If you wish to use a different payment method at the time of your appointment, please notify the front desk before your session begins. This card will also be used for all after hours appointments, telehealth appointments, missed appointments or late cancel appointments.

Cardholder's Name_____ Relationship_____

MC/VISA/DISC No._____ Exp. Date _____

Signature of Authorized User _____

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 7-8 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 Miranda Butler, 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 the office manager 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.

NOTICE TO CLIENTS: The Texas Behavioral Health Executive Council investigates and prosecutes professional misconduct committed by marriage and family therapists, professional counselors, psychologists, psychological associates, social workers, and licensed specialists in school psychology. Although not every complaint against or dispute with a licensee involves professional misconduct, the Executive Council will provide you with information about how to file a complaint. Please call 1-800-821-3205 for more information.

Texas Behavioral Health Executive Council, George H.W. Bush State Office Building, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701
Tel. (512) 305-7700 or 1-800-821-3205

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.

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? _____

_____

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

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

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?**

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:

_____

_____

_____

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: ☐ Yes ☐ No 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

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? ☐ No ☐ Yes

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.
Emily Gutierrez, MA, LPC-Associate
Supervised by Pam Cosart, MA, LPC-S

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: _____

_____

_____

_____

_____ _____

Emily Gutierrez LPC-Associate Date