

Woodlands Family Institute
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.

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Office Policies

FEE SCHEDULE

Standard rate: \$165.00 per standard 50 minute session. Cash or personal checks are accepted. Charges for other professional services are prorated on the bases of \$165 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 \$165 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

Medicare: All of our counselors/therapists at Woodlands Family Institute, P.C. have **opted out** of being a Medicare provider. All clients on Medicare, or are eligible for Medicare, must sign the federally mandated “Private Contract” to receive services at our practice. All services must be paid at the time of service, and neither WFI, its counselors/therapists, nor the client may file a claim to Medicare OR Medicare’s Supplemental Plans for reimbursement.

Are you on Medicare or Medicare Eligible? ____ yes ____ no

If yes, please notify your counselor/therapist BEFORE your first session so you can sign the Medicare Opt Out Private Contract. This is required for all Medicare or Medicare Eligible clients.

Medicaid: We are not accepting any Medicaid patients; we will only accept “Private Pay” patients. We will not file any claims to Medicaid for reimbursement of your medical services now or at any time in the future

_____ Initials indicating you have read and understand the information regarding Medicare/Medicaid

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.

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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-4:00pm. 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.

Woodlands Family Institute
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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.

If you have any questions about policies, procedures, or the therapeutic process, please ask. I am here to help!

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

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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 _____

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Financial Responsibility

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

Address/phone if different from client _____

Signature(s) _____

Relationship to client _____

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

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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

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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.

10200 Grogans Mill Rd, Suite 550

The Woodlands, Texas 77380

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- **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 Miranda Butler 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? _____

Woodlands Family Institute
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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): _____

Woodlands Family Institute
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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? _____

Woodlands Family Institute
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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:

Woodlands Family Institute
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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? _____

Woodlands Family Institute
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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

Woodlands Family Institute
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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: _____

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Licensed Professional Counselor

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

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Licensed Professional Counselor

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