Kirk Andrews, MA, LMFT, BC-DMT
LICENSED MARRIAGE AND FAMILY THERAPIST (MFT)

LAGUNA FAMILY THERAPY
Resources for Life

Dear New Client,

Welcome to my practice. I love my work as a psychotherapist and very much look forward to collaborating with you.

This document provides an overview of topics relevant to our work together. These topics refer to "you" as the client even if the client is your minor child. There are some policies and procedures that I may neglect to fully review with you initially because I am most interested in understanding you and your concerns. I felt writing them down would save time and avoid confusion. Please retain this agreement and read it at your leisure and please feel free to discuss any questions or concerns you have about these policies or any other matter at any time. As a potential consumer of psychological services you are entitled to be fully informed. I will gladly discuss any of these with you. Of course, I will bring up with you whatever matters seem to directly affect your particular concerns.

My view of psychotherapy is that you, as a client, are hiring me, as the therapist, to consult with you regarding growth issues or problems that significantly impact your life. Some of my clients view our relationship as coaching them to achieve their goals. One aspect of my practice is executive coaching for healthy people who wish to enhance their performance and communication in their profession or lives. If you are interested in coaching, please discuss with me in more detail.

The goals of therapy and coaching are best set by both client and therapist together, so that our agendas in working together can be clear and most effective. With these goals in mind, a treatment plan will be developed using the latest psychological information available for helping you.

Disclosure Statements

The following statements are to provide you with information concerning therapy, as well as the legal and ethical issues related to services provided by licensed psychologists in California, and federal rules and regulations concerning you.

TYPE OF THERAPY: Therapy is essentially a relationship between the client and the therapist. The client may be an individual, a couple or a family. The initial focus of the therapy is on understanding thoughts, emotions and life situations that concern the client. Therapy then offers the support, skills and directions that facilitate the client's desired changes.

As a client you have the ability to understand and implement change; you are responsible for deciding the ultimate course of action. Through a sequence of self-explorations, which include an investigation of your family history and a commitment to change personal behaviors, you learn more about yourself and the external factors that effect the quality of your life. You may find improved skills in the areas of communication, decision making, personal effectiveness, self-control and self understanding. Formal and informal assessments, readings, structured experiences, journal writing and "homework" are sometimes used to augment the therapy experience. You are in full control of what you want to accomplish in therapy and we decide together what methods to use. It is most helpful, I find, if you are as open and honest as possible about what you choose to share.

If I feel you can best be helped by a therapeutic method different from my own scope of practice I will discuss a referral with you.

My website contains additional information about types of therapy I may use and my professional background. A copy of your rights as a client and the ethical principles of the California Association of Marriage and Family Therapists are available in my office for you to read. I hope our work together will significantly increase your experience of well being, and accomplish your goals.

RISKS AND BENEFITS OF THERAPY: There are benefits as well as risks related to therapy. The desired benefits are your improved ability to identify problematic areas, evaluate reasonable options and take action in an honest manner. A good therapy or coaching experience also offers opportunities to learn important things about one's self, to acquire helpful life management skills and to integrate both past and present learning toward higher functioning. The risks include the awareness of negative feelings and situations, some of which may not be changed to your satisfaction. Some awareness may cause emotional disability or disruption to your current life. The possible realization that therapy is helpful and desired, but beyond the limits of your financial resources is also a risk.

You may wonder if there are any guarantees in the light of the benefits and risks presented here. In short, while I expect that therapy will be helpful, there is no guarantee that therapy with me will be the best way to reach your desired goals. Because every therapeutic experience is unique, it varies from individual to individual. Therefore it is vital that you feel free to discuss any concerns you have about the course of treatment with me at any time. As a client, you also have the right to seek a second opinion from another clinician.

RIGHTS OF CLIENTS: My practice is guided by the Ethical Code of the California Association of Marriage and Family Therapy. A copy of that code, as well as a statement of Clients Rights, is available in my office for you to read. Sexual intimacy between client and therapist is never appropriate during or following a therapeutic relationship. The State Board of Behavioral Sciences in Sacramento investigates reports of such behavior.

INDEPENDENT PRACTICE: While I share office space with several other very skilled professionals, we each practice completely independently and are each separately responsible for our own policies and practices.

Therapeutic Policies

TREATMENT SESSIONS: Therapy sessions are usually held once a week for fifty five minutes. Sessions are scheduled on a weekly basis until you and I mutually agree that a different time schedule is appropriate. Goals for therapy are determined within the first few sessions. These are periodically reviewed and refined. Termination occurs when both of us mutually agree that the goals have been satisfactorily addressed or there is some other reason to terminate, such as a required move. You have the right to terminate at any time; I ask that you discuss your concerns with me for at least one session before you leave.

THERAPY AND PHYSICAL SYMPTOMS: Physical symptoms are often the result of emotional stress. They can be reduced and even eliminated under certain therapy conditions. It is important, however, that an appropriate medical specialist review your current situation to ascertain the degree to which the symptom has a physical base. A physical exam is therefore required when a physical symptom is a primary concern. If there is a physical problem that affects your therapy, I will work closely with your medical specialist to coordinate treatments and services. It is important for you to let me know if you have persistent physical discomfort. I will discuss a referral to another specialist with you.

LIMITATIONS AS A THERAPIST: Because I have family responsibilities, I do not do hospital work or severe substance abuse cases. If we feel you require these special services, I will refer you to someone I trust who specializes in these areas. I will maintain contact with you and support you during that time.

MEDICATIONS IN PSYCHOLOGICAL THERAPY: Depending on symptoms and problems, medications may or may not be appropriate. As a psychotherapist I am not licensed to prescribe medication. In the event a consideration for possible medications for psychological distress seems necessary, then I will refer you and assist in obtaining a medical evaluation. It is your responsibility to inform me of any and all prescribed medications and changes is medications as they may significantly affect your mental status and therapy. It is also important that you are compliant with the course of treatment as prescribed by your physician. For some conditions however, therapy has been shown to be more effective than medications and I will inform you if I feel medications will affect or enhance your treatment.

CONFIDENTIALITY: The information presented in therapy is personal and confidential. Information is also legally protected. The only circumstances when information could be shared without your prior written and verbal permission are when there is a clear intention to do harm to yourself or to someone else, when your insurance company asks for routine information previously authorized and when a court subpoena is valid. I also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a dependent disabled adult or an elderly person. Please note that if you instigate a lawsuit, your mental status and all your records may become subject to court scrutiny. Even when I receive previously signed written authorizations from insurance or regarding legal matters, I will contact you to discuss whether I feel releasing all or some of the information is in your best interest. It is my general policy to forward all information to you, for you to release to your Insurance Company as you see fit.

ORIENTATION AND CONFIDENTIALITY IN COUPLE, AND/OR FAMILY THERAPY: When I treat you as part of a couple or family group, no information is released to outside parties without the written consent of all parties present. Minor children will also be asked for their consent. When we meet in individual sessions in the context of family therapy, no information is shared with other members of the family unless the individual (even though he/she may be a minor child) shares it himself/herself or indicates a willingness for me to share. My orientation to family and marriage therapy is that children and individuals do better when the family remains intact except in cases of domestic violence or child abuse.

REQUESTS FOR INFORMATION: Insurance companies, health maintenance organizations, and preferred provider organizations sometimes require extensive documentation of your diagnosis, treatment plans and progress. While I am happy to comply with such requests, I must charge for my preparation time and routine costs if lengthy reports are required. Fees for report preparation will be billable at $200 per hour and are not included in testimony charges.

Such organizations are not covered by legal protection of privilege or confidentiality and may have no ethical guidelines. It is my policy to contact you directly when I receive written requests even when the request includes written authorizations to release information. I do this so we can discuss exactly what you wish released and how I might accomplish this. You should be aware that by using third party payment, the releases you sign and/or the processing procedures followed might eliminate your legal protections of privilege and confidentiality. I find many of my clients are unaware of the existence of the Medical Information Bureau that has over 750 insurance companies as members. They share with other health, life and mortgage insurers, if you sign a general or specific release.

For these reasons and because of the HIPAA regulations discussed elsewhere, when I am asked by you to release information I mail or give the original and a copy to you with an envelope so that you may forward it as you choose.

LEGAL MATTERS: Some situations involve legal matters. If you are involved in a legal situation of any kind, you are expected to sign the retainer agreement at the beginning of therapy. This is for your protection and mine. See retainer agreement under forms if this applies to you.

RECORDS: I regularly keep written records of our sessions. These records include date of meeting, who was present, how long we met and brief notes regarding the issues we discussed. I also record quotes and specific details if issues of homicide, suicide, or abuse or neglect or other legal matters are discussed. I document calls to and from other care providers. These records are maintained seven (7) years after age 19 for a minor and seven (7) years for an adult per California guidelines. After that they are retained in either full or summary form for an additional eight (8) years. Fees for report preparation will be billable at $200 per hour and are not included in testimony charges.

CONSULTATION WITH PEERS: I routinely consult with my therapist peers regarding cases. This is to insure my objectivity and that I do not overlook possible avenues to help you. I do not use my clients' names and try to omit all identifying information. Confidential records of these contacts are kept with your records and I inform you of the discussion if I feel it is helpful to you. If you have any questions or discomfort about this, please do not hesitate to discuss this with me.

VOICE MAIL SERVICE: I have voice message service at 949-933-9761. If you do not receive a call back within 12 hours of when you leave a message, please call again because I may not have gotten the message. If it is a life threatening emergency and I can't be reached, call 911 or go your local hospital emergency room.

VACATION POLICY: I will always inform you about my plans to

be away from the office on the day(s) we usually meet. I always arrange for a trusted and skilled colleague to be on-call for me while I am away. Your signature on this form provides me with permission to share some information about your case with the on-call therapist covering for me. For each vacation, I will inform you what information, if any, I feel it necessary to share and with whom.

TELEPHONE CALLS, TEXTS (SMS), AND E-MAILS BETWEEN SESSIONS:

Routine calls for the purpose of scheduling or billing information are an expected part of my service and not billed. Telephone calls or emails that are primarily therapeutic in nature, occur frequently, and/or require more than ten minutes will be prorated and billed at the usual rate. Please do not use texts to communicate therapeutic information. Please know that texts, email correspondence and cellular phone calls cannot be considered completely confidential or secure. I can schedule telephone sessions for some clients if it is appropriate to their goals and treatment. Sometimes we have telephone appointments when a client is out of town. I cannot guarantee a timely response on emails so schedule changes and cancellations should be handled by phone. If you choose to email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

SOCIAL MEDIA AND INTERNET: As a therapist, my primary concern is to protect your safety, privacy and confidentiality. For these reasons, I do not follow or accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Instagram, etc). I do not use search engines (Google, Facebook, etc) to obtain information about current clients except in extremely rare crisis situations where I am concerned about your well-being.

You may find my practice listed on business review sites such as Yelp, Healthgrades, Bing, etc. These listings are generated by the business review sites independently from me and without my knowledge. Please know that this listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish but I would urge caution when sharing personally identifying information in a public forum. Due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I ask you to take your own privacy as seriously as I take my commitment of confidentiality to you.

PRIVACY AND VISIBILITY: Laguna Beach is a small town which can present some challenges to maintaining privacy for receiving mental health services. While unlikely, it is possible that you will recognize someone or be recognized by someone in the waiting room of the office. I urge all my clients to maintain their privacy and the privacy of others in and out of the office. Of course, I will maintain the confidentiality of all parties at all times. I also live in Laguna Beach, and you may encounter me accidentally or in a planned-expected manner in the community. Unless you tell me otherwise, I will neither acknowledge you in the community first, nor will I acknowledge working with you without your permission. Please feel free to discuss any concerns you might have about this.

FEES FOR SERVICES: The fee for service is $200 for 55 minute/hour session. It is best to pay when you arrive for your session as we may discuss challenging material and you may be more comfortable leaving directly when the session is over. Payment can be made with cash, credit card or a personal check. If you have insurance coverage, I will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss financial matters with me.

MISSED APPOINTMENTS AND CANCELLATIONS: Sometimes emergencies come up. If I need to cancel or change an appointment time, I will give you 24 hours notice, as I know you will have reserved the time for the appointment. If for any reason I cannot give you 24 hours notice, I will provide our next hour free of charge to you. Likewise, I expect that you will give me 24 hours notice if you must cancel the appointment. If, for any reason, you cannot let me know 24 hours in advance you will be charged the regular fee for the time reserved.

SIGNATURES

By signing below, you agree as follows:

I have read the materials presented in this disclosure statement.

My signature indicates that I understand the information, and agree with the conditions of therapy that are either stated or implied here, and I commit myself to compliance with them.

I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate.

I will make every effort to discuss my concerns about the progress of therapy with you before I terminate.

Client/Guardian Signature Date

Client/Guardian Signature Date

Kirk Andrews, MA, LMFT, BC-DMT Date

NOTICE OF PRIVACY PRACTICES

LAGUNA FAMILY THERAPY
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This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by me prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information. My practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

To provide treatment: We will use your health information within my office to provide you with the best healthcare possible. This may include administrative and clinical office procedures to schedule and coordinate care between doctors, and business office staff. In addition, we may share your health information with referring physicians, specialists, clinical laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorized health care providers treating patients even when the provider requesting the results did not originally order the tests.

To obtain payment: We may include your health information with an invoice used to collect payment for treatment you received in my office. We may do this with insurance forms sent to you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.

To conduct health care operations: Your health information may be used during performance evaluations of my staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

Communications: Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact me to make an appointment. These communications may include postcards, letters, and telephone reminders. I may share your health information with those you tell us will be helping you with any auxiliary treatments, medications, or payment. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.

Required by law: We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Workers' Compensation and similar programs.

You are entitled to receive a copy of the Notice of Privacy Practices

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

Signature:_____ Date: _____
(parent/guardian if patient is a minor)

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ACKNOWLEDGMENT OF RECEIPT
of Notice of Privacy Practices

As of April 14, 2003, medical and mental health practitioners are required by law to provide their patients with a Notice of Privacy Practices, reflecting new federal regulations relating to Personal Health Information (PHI). You do not have to read this Notice, you only need to acknowledge that it was given to you. Even before these new federal laws went into effect, I can assure you that I and other psychologists have been dedicated to protecting the privacy of their clients and the confidentiality of psychotherapy information and records.

I acknowledge that I have received a copy of the Notice of Privacy Practices provided by this office.

Signature: _____ Date: _____

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FAMILY HISTORY QUESTIONNAIRE

LAGUNA FAMILY THERAPY
Resources for Life

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Age today: _____

School Attending: _____ Location: _____

Home Address: _____

Home #: _____ Cell #: _____ Other Contact #: _____

Email: _____ Other Email: _____

Were you referred to Laguna Family Therapy? ☐ Yes ☐ No If yes, may I thank them for the referral?

Please give their name and contact information. _____

What questions would you like to have answered by this assessment? _____

_____

_____

What symptoms/behavior does your child exhibit that are of concern? _____

_____

_____

What have you/teachers tried (e.g. accommodations) that has helped your child? _____

_____

_____

FAMILY INFORMATION

Parents with whom child is now living:

Mother: _____ Age _____ Father: _____ Age _____

☐ Natural (biological) Mother
☐ Stepmother
☐ Adoptive Mother
☐ Foster Mother

☐ Natural (biological) Father
☐ Stepfather
☐ Adoptive Father
☐ Foster Father

Highest Grade Completed: _____ Highest Grade Completed: _____

Occupation: _____ Occupation: _____

The parents named above are: ☐ Married ☐ Separated ☐ Never Married ☐ Divorced ☐ Other _____

Custody Arrangement _____

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FAMILY INFORMATION, *continued*

Primary language spoken in the home, if other than English _____

Biological parents(s) (if different than previous page):

Mother: _____ Father: _____

Highest Grade Completed: _____ Highest Grade Completed: _____

Occupation: _____ Occupation: _____

Family structure and history (include siblings and other persons living in the home):

Name: _____ Relationship to child: _____ Age: _____

Name: _____ Relationship to child: _____ Age: _____

Name: _____ Relationship to child: _____ Age: _____

Name: _____ Relationship to child: _____ Age: _____

Name: _____ Relationship to child: _____ Age: _____

Name: _____ Relationship to child: _____ Age: _____

FAMILY MEDICAL HISTORY

Please list any major medical or psychiatric problems in immediate or extended family members (e.g., schizophrenia, mental retardation, alcoholism, depression, learning disabilities, etc.)

Relationship to child	Problem	Age of Occurence

PREGNANCY AND NEONATAL HISTORY

Problems during pregnancy [check all that apply and time of occurrence (in weeks)]:

☐ Infections _____ ☐ Toxic exposure _____

☐ Accidents _____ ☐ Gestational diabetes _____

☐ Medications _____ ☐ Toxemia _____

☐ X-ray exposure _____ ☐ Maternal emotional distress _____

☐ Other _____

Week of pregnancy when child was born: _____

Delivery type:

☐ Normal vaginal ☐ Vaginal, assisted with forceps or vacuum ☐ Breech delivery

☐ C-section, planned (please describe circumstances) _____

☐ C-section, emergency (please describe circumstances) _____

Duration of labor (in hours) _____ Type of anesthesia, if used _____

Birth weight _____ APGAR scores: 1 minute _____ 5 minute _____

Neonatal problems:

☐ Needed help breathing ☐ Born addicted/exposed to alcohol or other drugs

☐ Cardiac/heart problem ☐ Required incubator

☐ Severe infection ☐ Nursing/feeding problems/colic

☐ Jaundice/high bilirubin ☐ Bowel/urinary problems

☐ Other _____

Was baby discharged with mother? ☐ Yes ☐ No

Neonatal nutrition:

Breast fed? ☐ Yes ☐ No If yes: Exclusively breast fed from _____ to _____ months
Partially from breast fed from _____ to _____ months

Formula fed? ☐ Yes ☐ No If yes: Exclusively bottle fed from _____ to _____ months
Partially from bottle fed from _____ to _____ months

Solid food began at _____ months

Food allergies? ☐ Yes ☐ No If yes, list _____

DEVELOPMENTAL MILESTONES—Approximate month at which child:

- ☐ Sat up _____
- ☐ Crawled _____
- ☐ Took first step _____
- ☐ Walked unassisted _____
- ☐ Babbled _____
- ☐ Spoke single words _____
- ☐ Spoke 2 or 3 word sentences _____
- ☐ Verbally Related experiences _____
- ☐ Fed self with spoon _____
- ☐ Fed self with fork _____
- ☐ Ate neatly (minimum of spillage) _____
- ☐ Indicated bowel/bladder urgency _____
- ☐ Was habit trained _____
- ☐ Fully toilet trained (occasional accidents) _____

CHILDHOOD MEDICAL HISTORY

Child's current est. weight (lbs) _____ Child's current est. height (feet/inches) _____

Illnesses/diseases (check all that apply):

- ☐ Allergies (eczema, asthma, hay fever, medication reactions, food allergies)
- ☐ Operations
- ☐ Hospitalizations (other than delivery)
- ☐ Meningitis/encephalitis
- ☐ Head injuries
- ☐ Seizures/convulsions
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Repeated ear infections
- ☐ Required ear tubes
- ☐ Heart problems
- ☐ Breathing problems
- ☐ Exposed to toxic chemicals

If you checked any of the above, please describe the problem in more detail:

_____

_____

Child's current health is: ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Excellent

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NEURODEVELOPMENTAL DISORDERS

Communication:

Has your child ever had any of these communication problems? (check all that apply)

- ☐ Delayed onset of speech
- ☐ Stuttering, stammering, or lisping
- ☐ Auditory processing problems
- ☐ Echolalia, stereotypic speech, paraphasia
- ☐ Difficulty with word sequencing
- ☐ Deafness/difficulty hearing
- ☐ Receptive aphasia (difficulty understanding spoken words)
- ☐ Expressive aphasia/dysphasia (difficulty speaking)
- ☐ Other communication problems (describe)

_____

If you checked one of the above, describe any treatment your child your child was given:

Treatment	Provider	Duration/Frequency	Age Began	Age Ended
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs

Perceptual and motor development:

Has your child ever had any of these problems? (check all that apply):

- ☐ Blindness or poor vision
- ☐ Visual perception difficulties
- ☐ Cerebral palsy, spasticity, paralysis or dystonia
- ☐ Clumsiness, poor gross motor skills
- ☐ Poor fine-motor coordination
- ☐ Other perceptual motor problems (describe)

_____

If you checked one of the above, describe any treatment your child your child was given:

Treatment	Provider	Duration/Frequency	Age Began	Age Ended
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs

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NEURODEVELOPMENTAL DISORDERS, *continued*

Academic skills:

Has your child ever had any of these learning problems? (check all that apply):

- ☐ Dyslexia/alexia
- ☐ Difficulty writing or printing
- ☐ Difficulty in math/spatial relationships
- ☐ Difficulty remembering lessons
- ☐ Difficulty in spelling
- ☐ Takes an inordinately long time to finish homework, regardless of the subject of level of difficulty

If you checked one of the above, describe any treatment your child was given:

Treatment	Provider	Duration/Frequency	Age Began	Age Ended
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs
_____	_____	____ hrs _____ per week	_____ yrs	_____ yrs

MEDICATION HISTORY

Medication used for general health conditions:

Drug	Dosage(s)	Age Use Began	Still used?
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No

Medication used for psychiatric reasons or behavior control (including ADHD):

_____	AM _____ PM _____	_____ years	☐ Yes ☐ No
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No
_____	AM _____ PM _____	_____ years	☐ Yes ☐ No

ACADEMIC HISTORY

Current School: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Type of classroom (regular/resource/etc.)
Is your child currently receiving any accommodations (extra time, modified assignments, etc.)? ☐ Yes ☐ No

If "yes," please list: _____

Has your child ever repeated a grade? ☐ Yes ☐ No If "yes," which grade? _____

Has your child ever been in a special education class? ☐ Yes ☐ No

If you answered "yes" to the above question, describe the types of classes and dates of attendance.

_____

_____

Chronology of school attendance:

Age	Grade	School	Problems observed

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ACADEMIC HISTORY, *continued*

Any additional Information that would be helpful about school related issues:

_____

_____

STRENGTHS

Questionnaires always seem to ask more about problems than about strengths. Please use the space below to describe, in our own words, the good characteristics and qualities of your son/daughter. What do you like best about him/her? What are the things that he/she does that please you the most? What are his/her best qualities? Feel free to write as much as you want.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by_____ Date_____

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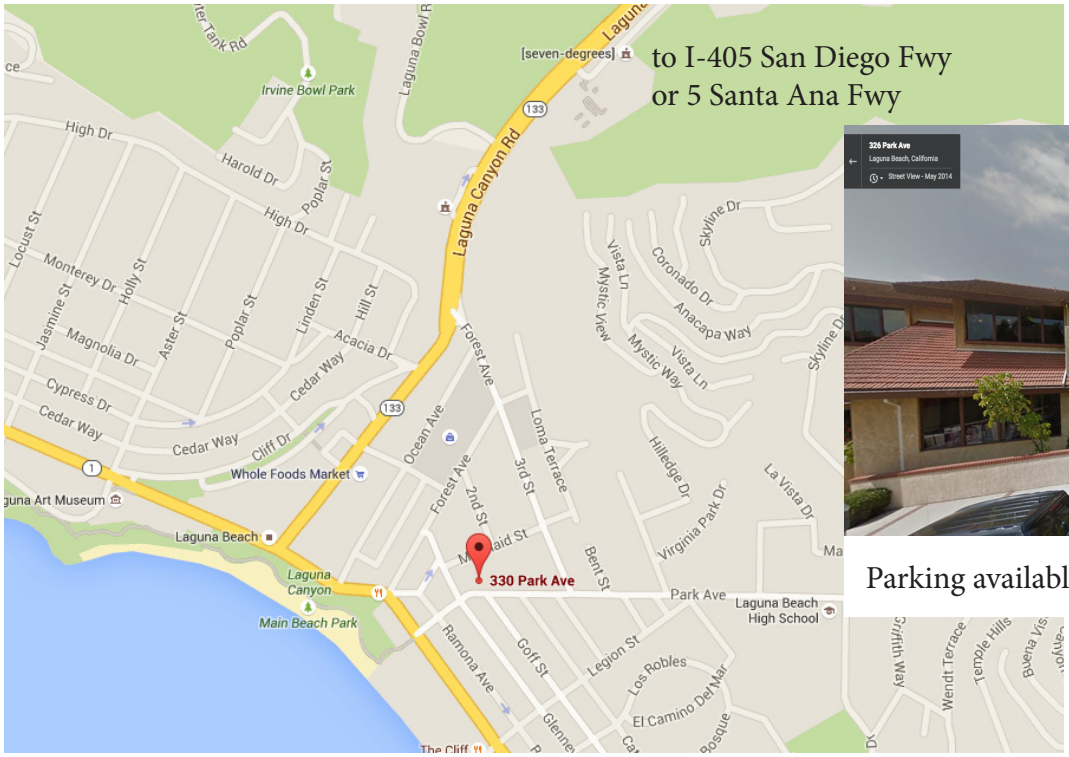
MAP AND DIRECTIONS

LAGUNA FAMILY THERAPY
Resources for Life



Parking available under the office building.

From 5 or 405 FREEWAYS:

Merge onto I-405 S/San Diego Fwy via the ramp to San Diego

Take exit 2 for California 133 N/California 133 S toward Laguna Beach/Laguna Cyn Road

Keep right at the fork, follow signs for State Route 133 S/Laguna Beach and merge onto CA-133 S

Take left onto Forest Ave (this turns into 3rd St)

Continue straight onto 3rd St (very large hill)

Turn right onto Park Ave
- Destination will be on the right, before the stop sign

Laguna Family Therapy
330 Park Ave, Ste. 7
Laguna Beach, CA 92651

Mary (949) 910-9344
Kirk (949) 933-9761

From the SOUTH on PCH 1:

Head North on PCH 1

Turn right onto Laguna Ave

Continue onto Park Ave
- Destination will be on the left

From the NORTH on PCH 1:

Head South on PCH 1

Slight left onto Park Ave

Turn left at Ramona Ave

Turn right onto Glenneyre St

Turn left onto Park Ave
- Destination will be on the left