

George J. Joumas, M.A. Banner Behavioral Health-Banner Good Samaritan Medical Center

925 E. McDowell Road, 4th Floor
Phoenix, Arizona 85006
(602) 839-2490 (602) 839-4546 / Fax (602) 839-6988

Individual, Couple & Family Therapy
Children, Adolescents and Adults

PERSONAL INFORMATION FORM

Today's Date: _____

Patient's Name: _____ SS # _____ - _____ - _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: (_____) _____ Date of Birth _____ Age: _____ M F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: Yes No

Spouse's / SO's / Parent's Name: _____ SS # _____ - _____ - _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Date of Birth _____ Age: _____ M F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: Yes No

Insurance Information

Name of Responsible Party / Policy Holder: (Patient, Spouse or Parent) _____

Relationship to Patient self parent spouse other _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Date of Birth _____ Age: _____ M F

Employer: _____ Work Phone: _____ Ex _____
May we contact at work: Yes No

Primary Insurance: _____

ID Number: _____ Group Name (Number): _____ SS # _____ - _____ - _____

Referred by: _____

Family Physician: _____ Phone: _____

Emergency Contact (Other than Spouse): _____

Relation: _____ Phone: _____

AUTHORIZATION FOR DIRECT PAYMENT - RELEASE OF RECORDS

I hereby authorize insurance payments directly to George J. Joumas, M.A. / BBH-BGSMC I hereby authorize the release and exchange of pertinent psychological, psychiatric, educational, and/or medical records for insurance purposes / case management purposes only.

Signature of Insured or Responsible Party (Parent if Minor)

Date

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PERSONAL INTAKE / HISTORY

Patient Name: _____ **Education** _____ **Current School:** _____

Current Relationship Status: Single Living with Partner Married Divorced Separated Widowed
Number of Marriages / Significant Partner Relationships _____ **Religious / Spiritual Tradition:** _____

PRESENTING PROBLEMS

Brief explanation of why you are currently seeking psychological support. _____

_____ **What is the duration of this problem (s)** _____

Do you have any of the current or past psychological problems? *Please check appropriate boxes that apply*

SYMPTOM OR PROBLEM **NO** **current problem** **past problem** **Age when first a problem**

CURRENT SYMPTOMS CHECKLIST

Depression	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Bipolar disorder	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Anxiety / Panic disorder	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Obsessive - Compulsive Disorder [OCD]	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Post Traumatic Stress Disorder [PTSD]	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Psychosis, delusions, hallucinations	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Paranoia	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Attention Deficit / Hyperactivity Disorder [ADHD]	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Other learning / educational disorder	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Suicidal thoughts / feelings / ideation	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Homicidal thoughts / feelings / ideation	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Self-mutilation	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Anger, agitation or aggression	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Victim of emotional, physical or sexual abuse	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Perpetrator of emotional, physical or sexual abuse	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Gambling or other addictive behavioral problems	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Eating disorder, bingeing and / or purging	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____
Other _____	<input type="checkbox"/> no	<input type="checkbox"/> current	<input type="checkbox"/> past	_____

SUBSTANCE USE HISTORY

SUBSTANCE	AGE 1ST USE	LAST USE	<input type="checkbox"/> NO USE	<input type="checkbox"/> current USE	<input type="checkbox"/> current ABUSE	<input type="checkbox"/> past Problem
Nicotine, cigarettes, smokeless tobacco	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Alcohol	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Amphetamines , speed or other stimulants	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Barbiturates, downers	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Caffeine	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Cannabis (marijuana) or hashish	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Cocaine, crack	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Ecstasy	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Hallucinogen (LSD, Angel Dust, Mescaline)	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Inhalants (glue, gas) "huff"	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Opiates (Heroin, Methadone, Codeine, etc.)	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past
Prescription or other _____	_____	_____	<input type="checkbox"/> no	<input type="checkbox"/> use	<input type="checkbox"/> abuse	<input type="checkbox"/> past

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TREATMENT HISTORY

Have you had any previous psychological consultations? No Yes When: _____

Where: _____ Dr. / Therapist: _____

Have you ever been hospitalized for psychiatric reasons? No Yes When: _____

Current or prior psychiatric medications No Yes

Where: _____ Dr. / Therapist: _____

Any other current psychiatric / psychological supports? No Yes Where: _____

Medication	dosage	frequency	start date	end date	side effects	helpful
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Other current or prior non psychiatric medications No Yes

Name of current psychiatrist: _____ Phone : _____

Medication	dosage	frequency	start date	end date	side effects	helpful
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

MEDICAL HISTORY

Name of current primary care physician: _____ Phone : _____

Do you have any current or past medical problems ? Please list and include treatments, including physicians and medications.

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FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD

Name	Relationship	Age	Occupation	Marital Status

PATIENT'S FAMILY OF ORIGIN (Mother, Father, Siblings, if different from above)

Name	Relationship	Age	Occupation	Marital Status

Military history: No Yes No Problems Problems When: _____

OTHER HISTORY

Financial: No Problems Problems Explain: _____

Living situation / housing: No Problems Problems Explain: _____

Employment: No Problems Problems Explain: _____

Legal History: No Problems Problems Explain: _____

Social support system: No Problems Problems Explain: _____

Family: No Problems Problems Explain: _____

Cultural / spiritual: No Problems Problems Explain: _____

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AUTHORIZATION FOR RELEASE AND / OR EXCHANGE OF INFORMATION

I understand that my records and information obtained during consultation / therapy are confidential and protected under the federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Prt 2*, and cannot be disclosed, exchanged or obtained without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that information based on this authorization has already been released, exchanged or obtained. This consent will automatically expire:

60 Days post completion of treatment Other _____

Information to be Released, Exchanged, and/or Obtained:

Psychological Psychiatric Educational Testing Medical Alcohol Drug
 Other _____

Specific Information to be Released, Exchanged, and/or Obtained:

Diagnosis Dates of Treatment Treatment Plan Treatment Progress Discharge Summary
 Test results / data History and Physical Lab results Summary of Treatment
 Complete records Other _____

Purpose

Facilitate treatment, coordinate services and assure continuity of care To assist in making referral
 Communication with insurance or managed care case management To arrange leave of absence from work or return to work To comply with court order, subpoena, employer request, or other appropriate requests for information.
 Other _____

When completed and signed, this document authorizes the release and/or exchange of confidential information regarding the following patient:

Name: _____ Date of Birth _____

Between: **George J. Joumas, MA, Banner Behavioral Health-BGSMC 925 E. McDowell Rd 4th Fl, Phoenix, Arizona 85006 (602) 839-2490, (602) 839-4546, Fax (602) 839-6988**

And **RELEASE** Insurance Company / Managed Care Case Manager _____

Primary Care Physician [PCP] _____

Signature of Patient / Parent / Legal Guardian Date

Witness Date

And **OBTAIN** Insurance Company / Managed Care Case Manager _____

Primary Care Physician [PCP] _____

Signature of Patient / Parent / Legal Guardian Date

Witness Date

George J. Joumas, M.A

Samaritan Behavioral Health Center - Good Samaritan Regional Medical Center
925 East McDowell Rd, 4th Floor, Departments of Psychology & Psychiatry
Phoenix, Arizona 85006 (602) 839-2490 / (602) 839-6800 Fax (602) 839-6988



Banner Health Arizona
A division of Banner Health System

CONSENT FOR TREATMENT OF MINOR (S) AGE 16 & UNDER

Patient's (Child's) Name: _____ Date of Birth _____ SS # _____

I / We _____
Print parental / custodial name (s)

am / are the legal custodial parent (s) of _____

and give my / our permission to George J. Joumas, M.A. to provide psychological / counseling services to my / our child.

Signature of Parent Date

Signature of Parent Date

Witness Date

----- **WHEN CHILD'S PARENTS ARE DIVORCED OR SEPARATED** -----

I have shared / partial custody and am required to have _____ receive notification of my child's (this patient's) treatment. I understand that I am required to give George J. Joumas, M.A. A copy of court documents describing divorce custody agreement.

Signature of Parent Date

Witness Date

Name of Parent to be notified Phone

Address City State Zip Code

I have full custody and am not required to have _____ receive notification of this patient's treatment. I understand that I am required to give George J. Joumas, M.A. a copy of court documents describing divorce custody agreement.

Signature of Parent Date

Witness Date

Arizona Rule R9-20-201 (E)(5) required that the name of individuals to whom this child / patient may be released:

1) _____ 2) _____

3) _____ 4) _____

Signature of Parent Date

Witness Date

Child & Adolescent Developmental Questionnaire

In order to serve you and your child better, please answer the following questions regarding your child. Feel free to add any extra comments on a separate sheet.

Name of Child: _____ DOB: _____ Today's Date: _____

Age: _____ Name of School: _____ Grade: _____

Person completing this form: _____ Relation to Child: _____

PRESENTING CONCERNS & PROBLEMS

1. What are the chief concerns you have about your child? _____

A. When did you first notice this problem? _____

B. At what point did this problem become a significant concern to you? _____

C. What types of **evaluations** / medical - diagnostic work-ups / psycho - educational testing / psychiatric consults, etc., have already been performed for this problem?

D. What types of **treatment** have already been used for this problem?

Please check *Please explain*

Psychotherapy _____

Psychiatric _____

Medications _____

Medical _____

Educational _____

Diet _____

Other _____

E. What has been helpful, and what has not been helpful? _____

F. What interventions / corrective actions have you also attempted? _____

- G. Of your interventions, what has been helpful, and what has not been helpful? _____

- H. Was there a precipitating event to seeking support at this time? _____

- I. How are you hoping treatment will be helpful? _____

PREGNANCY, DELIVERY & BIRTH HISTORY

2. During the pregnancy, did the biological mother use any of these substances?
If yes please check box
 Medications (over the counter) Medications (prescribed)
 Tobacco Alcohol Street drugs
 Unknown
Please explain briefly those checked _____

3. Mother's age during pregnancy of this child: _____ years
4. During the pregnancy, did the biological mother have any of the following:
If yes please check box
 vaginal infections anemia diabetes
 German measles other infections high fevers
 vaginal bleeding amniocentesis kidney problems
 high blood pressure premature labor no prenatal care
 excessive weight loss emotional problems accidents / falls
 excessive weight gain other
Please explain briefly those checked _____

5. Was pregnancy full term? Yes No - If no how long? _____ weeks
6. Was labor spontaneous induced.
7. How long was labor? _____ hours
8. Was anesthesia used during delivery? Yes What Type? _____
9. Delivery was (please check) vaginal cesarean section
10. What was baby's birth weight? _____ pounds
11. At birth, did the baby have any of the following conditions:
If yes please check box
 forceps delivery cord around neck twin or multiple birth
 trouble breathing resuscitation blood transfusion
 jaundice blood transfusion intensive care
 birth defects seizure / fits fevers or low temperature
 physical injuries other
Please explain briefly those checked _____

12. How long did the baby stay in the hospital? _____ days
13. Please list any other concerns or problems regarding birth. _____

DEVELOPMENTAL HISTORY

14. Is your child adopted? yes no
 A. Does your child know of the adoption? yes no
 B. If no, do you intend to tell your child? yes no
 C. At what age was the child placed in your home? _____
 D. At what age was the child adopted? _____
15. Was the baby breast fed _____ months bottle fed _____ months

16. Did the baby have any feeding problems? yes no
 17. Did either the mother or father have any emotional problems, physical problems or other significant stresses during the child's early development? yes no
 If yes please explain _____

18. Early development. At what age did your child first:

Behavior	Certain	Estimate		
	Age	Early	On Time	Late
Sit up				
Crawl				
Stand alone				
Speak real words				
Walk by self				
Feed self				
Use two word sentences				
Dress self				
Toilet trained				
Ride a tricycle				
Ride a bicycle				
Tie own shoes				

19. As an infant:
 A. Did your child like to be held? yes no
 B. Was your child quiet? yes no
 C. Was your child alert? yes no
 20. Your child's dominant handedness: right left both
 21. Did your child have any problems with gross or fine motor skills, or muscle development? yes no
 If yes explain _____

22. Does your child demonstrate any of the following language developmental problems?
 If yes please check box
 trouble finding the right word too few words in sentences
 unconnected thoughts repeats words / phrases over & over
 has seen a speech therapist stuttering
 problems with speech clarity has had hearing evaluated
 problems with following directions seems confused when spoken to
 Please explain briefly those checked _____

23. Have you ever been concerned or told that your child experienced any of the following developmental lags?
 If yes please check box
 growth social coordination
 Please explain briefly those checked _____

24. Did your child demonstrate any developmental lags in the following pre-academic skills?
 If yes please check box
 numbers colors shapes letters
 understand names of objects follow simple commands organized play
 Please explain briefly those checked _____

HEALTH & MEDICAL HISTORY

25. Does your child have, or has your child had any of the following medical problems?
If yes please check box

A. Nervous System

- | | |
|---|--|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Cerebral contusion or other head injury |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Coordination difficulties |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Headache, cluster | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Palsy, cerebral or other |
| <input type="checkbox"/> Seizure, grand mal | <input type="checkbox"/> Petit mal |
| <input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> Tremor, benign / essential |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Unexplained anger or sudden and unprovoked emotional outbursts | <input type="checkbox"/> Other |

B. Circulatory System

- | | | |
|---|---|---|
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Murmur | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Other | | |

C. Respiratory System

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis, acute or COPD |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Other |

D. Neoplasms

- | | | |
|-----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Neoplasm, benign or malignant | <input type="checkbox"/> Other |
|-----------------------------------|--|--------------------------------|

E. Endocrine

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyper / Hypothyroidism | <input type="checkbox"/> Testicular Dysfunction |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Sexual development and puberty, delayed or precocious | |
| <input type="checkbox"/> Other | | |

F. Nutritional

- | | | |
|---------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Mineral or vitamin deficiency | <input type="checkbox"/> Other |
|---------------------------------------|--|--------------------------------|

G. Metabolic

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Dehydration | <input type="checkbox"/> Electrolyte imbalance | <input type="checkbox"/> Fluid overload / retention |
|--------------------------------------|--|---|

H. Digestive System

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Appendicitis, acute | <input type="checkbox"/> Colitis, ulcerative | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Other |

I. Genitourinary System

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Urinary tract infection [UTI] | <input type="checkbox"/> Other | |

J. Hematological

- | | | |
|---------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Other | | |

K. Eye

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Visual loss | <input type="checkbox"/> Other vision problem |
|--------------------------------------|---|

L. Ear, Nose, and Throat

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Common cold, frequent | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Laryngitis, acute |
| <input type="checkbox"/> Rhinitis, allergic | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Other | |

M. **Musculoskeletal System and Connective Tissue**

- Arthritis
- Scoliosis
- Other
- Disc disorder
- Strains / sprains
- Fracture
- Spasticity

N. **Skin**

- Acne
- Eczema
- Other
- Birth marks
- Hair loss
- Dermatitis
- Psoriasis

O. **Congenital Malformations & Chromosomal Abnormalities**

- Cleft lip or palate
- Undescended testicle
- Fetal alcohol syndrome
- Other
- Spina bifida

P. **Infectious**

- Chicken pox
- Herpes
- Mumps
- Other
- Hepatitis
- Influenza with pneumonia
- Rubella
- High fevers
- Measles
- Salmonella

Q. **Overdose**

- Lead poisoning
- Other poisoning

R. **Sexual**

- Sexual abuse
- Frequent masturbation
- Birth control
- Promiscuity

S. **Sleep Problems**

- Problems falling asleep
- Sleepwalking
- Problems staying asleep
- Nightmares

T. **Behavioral**

- Head banging
- Nail biting
- Thumb sucking

Please explain briefly those checked and mark age at which they occurred next to check mark _____

26. Describe treatments and supports for medical problems listed above. _____

27. Has your child received any inpatient hospitalization care? yes no
If yes, please list ages, reason, and length of each hospitalization. _____

28. Is your child **currently** taking any medication? yes no *If yes please list.*
Medicine Dosage / Frequency Reason Start Date

29. Medication **History.** Has your child taken medication to help with behavioral, emotional or medical problems?

yes no *If yes please list.*

Age Medicine Dosage / Frequency Reason Reason stopped

30. Has your child undergone any special medical diagnostic tests, i.e., EEG, MRI, CT scan, PET scan, blood tests. yes no

If yes, please list ages, test, reason, and result.

30. Please check the appropriate boxes to indicate you child's present or past, use, abuse or dependency of drugs and / or alcohol.

	Use	Current Abuse	Dependency	Use	Past Abuse	Dependency
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine or other stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis (Marijuana)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalants (gas, glue, industrial solvents, paint)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiate (heroin, codeine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCHOOL AND ACADEMIC HISTORY

31. Please indicate your impression of your child's academic potential to learn.

superior / gifted above average average low

32. Please indicate your impression of your child's current academic performance. Achieving at:

expected level below level above level

33. My child *please check appropriate boxes*

has difficulty with reading has difficulty with arithmetic has difficulty with spelling

has difficulty with writing does not like school

34. Please rate the level that the following items impact your child's academic success.

	not at all	mildly	moderately	severely
poor concentration / attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
distractibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tendency to give up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
inconsistent performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
disorganization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
day dreaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
low frustration tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anxiety / depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rapidly shifting tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor handwriting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
impulsivity / interrupting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Has your child ever been identified, or suggested to have:

Attention deficit (with or with out hyperactivity) disorder? yes no

Learning disorder ? yes no
If yes, please describe _____

36. Does your child receive any special education services? yes no
If yes, please describe _____
37. Have any psychological / educational diagnostic testing been performed? yes no
If yes, please describe _____
38. Has your child ever been: retained a grade expelled
 advanced a grade suspended
If yes, please describe _____

SOCIAL

39. Please describe your child's social interaction:
- | | | |
|---|------------------------------|-----------------------------|
| makes friends easily | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| has a best friend | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| plays well with others | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| shares easily | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| follows rules | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| leads other children | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| tends to be a follower | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| enjoys both playing with others and being alone | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| prefers to be alone | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| enjoys team sports | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| easily influenced | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| helps others | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| bullies others | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| fights more than others | <input type="checkbox"/> yes | <input type="checkbox"/> no |

EMOTIONAL / PSYCHOLOGICAL

40. Please check any of the following that describes your child's characteristics, behaviors or symptoms.

- | | |
|---|--|
| <input type="checkbox"/> fidgets | <input type="checkbox"/> difficulty remaining seated |
| <input type="checkbox"/> easily distracted | <input type="checkbox"/> difficulty awaiting turn |
| <input type="checkbox"/> often blurts out answers to questions before completed | <input type="checkbox"/> difficulty following instructions |
| <input type="checkbox"/> problems with attention and concentration | <input type="checkbox"/> shifts from one activity to another |
| <input type="checkbox"/> difficulty playing quietly | <input type="checkbox"/> often talks excessively |
- Please continue to check all that apply
- | | |
|--|--|
| <input type="checkbox"/> often interrupts or intrudes | <input type="checkbox"/> often does not listen |
| <input type="checkbox"/> impulsive | <input type="checkbox"/> often takes dangerous risks |
| <input type="checkbox"/> often engages in physically dangerous activities | |
| <input type="checkbox"/> often loses temper | <input type="checkbox"/> often argues with adults |
| <input type="checkbox"/> often deliberately does things that annoy other people | <input type="checkbox"/> disobedient, defiant |
| <input type="checkbox"/> often blames others for own mistakes | <input type="checkbox"/> is often angry or resentful |
| <input type="checkbox"/> is often sensitive or easily annoyed by others | <input type="checkbox"/> often swears or uses obscene language |
| <input type="checkbox"/> attention seeking, "show-off" | <input type="checkbox"/> dominates, bullies, threatens |
| <input type="checkbox"/> boisterous, noisy | |
| <input type="checkbox"/> has stolen others' property while physically confronting them | <input type="checkbox"/> lies, cheats often |
| <input type="checkbox"/> has stolen with out confrontation | <input type="checkbox"/> physically cruel to people |
| <input type="checkbox"/> ran away from home overnight at least twice | <input type="checkbox"/> often truant |
| <input type="checkbox"/> often initiates physical fights | <input type="checkbox"/> deliberate fire setting |
| <input type="checkbox"/> destroyed others' property | <input type="checkbox"/> breaking and entering |
| <input type="checkbox"/> forced someone else into sexual activity | <input type="checkbox"/> cruel to animals |
| <input type="checkbox"/> expressed homicidal ideation | <input type="checkbox"/> used a weapon in a fight |
| <input type="checkbox"/> is loyal to delinquent friends | <input type="checkbox"/> belongs to a gang |

- unrealistic & persistent worry that something will happen to you or other parent
- frequent nightmares about separation from you / other parent
- frequent physical pains, aches, upset stomach
- frequent complaints of nervousness, anxiety
- depressed or irritable mood most of the day, nearly every day
- diminished pleasure or satisfaction in activities
- excessive inappropriate guilt
- low or decreased energy, increase fatigue
- increased or decreased sleep, disrupted sleep
- repeated unusual movements
- excessive reaction to noise or fails to react to loud noises
- excessive concern regarding cleanliness, orderliness, smells
- motor tics
- can't get to the point, loses train of thought
- disoriented, confused
- incoherent speech
- excessive clinging, dependence
- explosive temper with minimal provocation
- decreased or no interest in friends and peers
- withdrawn
- cold and unresponsive
- persistent school refusal
- ongoing refusal to sleep alone
- avoidance of being alone
- inability to relax
- unrealistic worry about future events
- excessive distress when away from you or home
- agitation or sluggishness
- expressed feelings of worthlessness
- expressed feelings of hopelessness
- poor appetite or overeating
- suicidal thoughts or actions
- odd postures
- overreacts to touch
- compulsive rituals
- vocal tics
- bizarre ideas or behaviors
- hallucinations, paranoia
- excessive mood swings
- excessive reaction to change in routine
- panic / anxiety attacks
- won't talk
- shy, timid, bashful
- stares blankly

FAMILY HISTORY

41. Your child's family of origin (parents, siblings) and those now in household.

Name	Relationship	Age	Check if currently living in home
	Mother		
	Father		

42. History for parents:

	Father	Mother
Occupation		
Highest grade completed in school		
School Problems Learning Speech Behavioral		
Medical Problems		
Psychiatric / Psychological Problems or treatment		

43. History for other family members (siblings, grandparents, aunts, uncles):

Check	Condition	Relationship to Child
	Alcoholism or other substance abuse	
	Cancer	
	Diabetes	
	Heart trouble	
	Psychological Problems	
	Depression	
	Suicide attempt	
	Other: _____	

I know this was long -- Thank you , very much, *George J. Joumas, M.A.*