

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