

4545 East Shea Blvd., Suite 112  
Phoenix, Arizona 85028  
(602) 392-2012 Confidential Voice Mail / (602) 494-7110 / (602) 494-1724 FAX

Individual, Couple & Family Therapy  
Children, Adolescents and Adults  
www.joumasconsulting.com

**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. 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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**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

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**INFORMED CONSENT FOR TREATMENT**

I have chosen to receive psychotherapy / counseling services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that there is no assurance that I will feel better, and that material may be discussed that may be upsetting in nature. I understand that psychotherapy / counseling is a collaborative effort between my therapist and myself. I understand that I have the right to be informed of the various steps and activities involved in receiving services. I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.

I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and / or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.

I understand that George J. Joumas, M.A. will respond to written and phone request for medical records in a timely fashion. Request for release of records should include a signed written authorization of release identifying the individual and/or organization to which the records are released, and that confidential medical records are stored, accessed and released in accordance with Arizona state regulations (32-3211).

I understand that insurance companies require that my name and an identification number be place on every page of my medical record, and that a chart number (i.e..., JG1999125, initials date of intake) will be used rather than my insurance ID (social security number).

(Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of \$35.00 for any check returned for [NSF] non-sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e..., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

(Initial) I understand that George J. Joumas, M.A. requires the minimum of a 24 hour notice if I will be unable to attend my appointment. I understand that if I no show for a scheduled appointment or fail to give minimum of a 24 hour notice, **I will be charged full fee for that session** (unless limited by my insurance). If I need to cancel with less than 24 hours, I will leave a message with the answering service and not on Mr. Joumas's voice mail. I also understand that George Joumas holds himself responsible and abides by this same no show / late cancellation policy. Mr. Joumas will reimburse you should he no show or late cancel an appointment, or offer you a free makeup session. I also understand that a pattern on my part, of no show or failure to give notice of cancellation, will be discussed with my therapist with regards to current motivation or appropriateness for treatment and may result in a therapeutic discharge and/or referral back to my insurance company. I also understand that there will be additional fees for reports (e.g. for purpose of disability, legal, court, etc.).

I understand that in the case of a *"If this is a life threatening or other emergency"* (as instructed on Mr. Joumas's voice mail) *"I will call 602-494-7110 and ask that I be contacted immediately. After normal office hours please call my service at 480-308-1513 and ask that I be contacted immediately. If they are not able to reach me immediately, please call your referring insurance or managed care company and ask for a Crisis Case Manager and / or call 911."* I understand that many insurance companies require me to call their Crisis Manager if I am unable to reach George Joumas immediately.

I have read and understand the above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
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

**OTHER HISTORY**

**Military history:**  No  Yes  No Problems  Problems When: \_\_\_\_\_

**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, Shea Mental Health, 4545 E. Shea Blvd., Suite 112, Phoenix, Arizona 85028 (602) 494-7110 , (602) 494-1724 Fax (602) 392-2012 voice mail**

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

## 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*
- |   |   |
|---|---|
| <input type="checkbox"/> Medications (over the counter) | <input type="checkbox"/> Medications (prescribed) |
| <input type="checkbox"/> Tobacco                        | <input type="checkbox"/> Alcohol                  |
| <input type="checkbox"/> Unknown                        | <input type="checkbox"/> Street drugs             |
- 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*
- |  |   |  |
|--|---|--|
| <input type="checkbox"/> vaginal infections    | <input type="checkbox"/> anemia             | <input type="checkbox"/> diabetes          |
| <input type="checkbox"/> German measles        | <input type="checkbox"/> other infections   | <input type="checkbox"/> high fevers       |
| <input type="checkbox"/> vaginal bleeding      | <input type="checkbox"/> amniocentesis      | <input type="checkbox"/> kidney problems   |
| <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> premature labor    | <input type="checkbox"/> no prenatal care  |
| <input type="checkbox"/> excessive weight loss | <input type="checkbox"/> emotional problems | <input type="checkbox"/> accidents / falls |
| <input type="checkbox"/> excessive weight gain | <input type="checkbox"/> 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*
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> forceps delivery  | <input type="checkbox"/> cord around neck  | <input type="checkbox"/> twin or multiple birth    |
| <input type="checkbox"/> trouble breathing | <input type="checkbox"/> resuscitation     | <input type="checkbox"/> blood transfusion         |
| <input type="checkbox"/> jaundice          | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> intensive care            |
| <input type="checkbox"/> birth defects     | <input type="checkbox"/> seizure / fits    | <input type="checkbox"/> fevers or low temperature |
| <input type="checkbox"/> physical injuries | <input type="checkbox"/> 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

- |   |  |
|---|--|
| <input type="checkbox"/> trouble finding the right word     | <input type="checkbox"/> too few words in sentences          |
| <input type="checkbox"/> unconnected thoughts               | <input type="checkbox"/> repeats words / phrases over & over |
| <input type="checkbox"/> has seen a speech therapist        | <input type="checkbox"/> stuttering                          |
| <input type="checkbox"/> problems with speech clarity       | <input type="checkbox"/> has had hearing evaluated           |
| <input type="checkbox"/> problems with following directions | <input type="checkbox"/> 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 \_\_\_\_\_

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26. Describe treatments and supports for medical problems listed above. \_\_\_\_\_

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

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

---



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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*

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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 your child's present or past, use, abuse or dependency of drugs and / or alcohol.

	Current			Past		
	Use	Abuse	Dependency	Use	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                     |
| <input type="checkbox"/> unrealistic & persistent worry that something                 | <input type="checkbox"/> persistent school refusal             |

- will happen to you or other parent
- ongoing refusal to sleep alone
  - 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
  - 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
	<b>Mother</b>		
	<b>Father</b>		

42. History for parents:

	Father	Mother
<b>Occupation</b>		
<b>Highest grade completed in school</b>		
<b>School Problems</b> <b>Learning</b> <b>Speech</b>		

<b>Behavioral</b>		
<b>Medical Problems</b>		
<b>Psychiatric / Psychological Problems or treatment</b>		

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

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

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

4545 East Shea Blvd., Suite 112  
Phoenix, Arizona 85028  
(602) 392-2012 Confidential Voice Mail / (602) 494-7110 / (602) 494-1724 FAX

Individual, Couple & Family Therapy  
Children, Adolescents and Adults  
www.joumasconsulting.com

**INFORMED CONSENT FOR TREATMENT [Patient Copy]**

I have chosen to receive psychotherapy / counseling services. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that there is no assurance that I will feel better, and that material may be discussed that may be upsetting in nature. I understand that psychotherapy / counseling is a collaborative effort between my therapist and myself. I understand that I have the right to be informed of the various steps and activities involved in receiving services. I will attempt to work with my therapist to develop and follow a plan of treatment. I also understand that I have the right to humane care and protection from harm, abuse, or neglect. I understand that I have the right to make an informed decision whether to accept or refuse treatment.

I understand that confidentiality of all records or information collected about me, and all information discussed in consultation and / or therapy sessions will be held in accordance with state and federal laws (42 CFT Prt 2) and cannot be released or disclosed without my written consent unless otherwise provided for in state and federal regulations. I understand that state and local laws require that my therapist report all cases of physical or sexual abuse of minors or the elderly. I understand that state and local laws require that my therapist report all cases in which there exists a clear danger to self or others.

I understand that George J. Joumas, M.A. will respond to written and phone request for medical records in a timely fashion. Request for release of records should include a signed written authorization of release identifying the individual and/or organization to which the records are released, and that confidential medical records are stored, accessed and released in accordance with Arizona state regulations (32-3211).

I understand that insurance companies require that my name and an identification number be placed on every page of my medical record, and that a chart number (i.e..., JG1999125, initials date of intake) will be used rather than my insurance ID (social security number).

(Initial) I understand that my portion of therapeutic expenses (insurance co-pay or deductible) is due at the conclusion of each session, and that I am responsible for payments not made by my insurance (within the limits of my insurance contract). I understand that I will be charged a fee of \$35.00 for any check returned for [NSF] non-sufficient funds. I also understand that I will be responsible for my portion of balances and fees (collection fee of 50% of balance) for balances that have not been paid in 90 days and turned over to a collection agency, and subject to reporting to credit bureau. I also agree to give accurate and current billing information (i.e..., insurance and billing address) and understand that incorrect information may result in my account being turned over immediately to a collection agency.

(Initial) I understand that George J. Joumas, M.A. requires the minimum of a 24 hour notice if I will be unable to attend my appointment. I understand that if I no show for a scheduled appointment or fail to give minimum of a 24 hour notice, **I will be charged full fee for that session** (unless limited by my insurance). If I need to cancel with less than 24 hours, I will leave a message with the answering service and not on Mr. Joumas's voice mail. I also understand that George Joumas holds himself responsible and abides by this same no show / late cancellation policy. Mr. Joumas will reimburse you should he no show or late cancel an appointment, or offer you a free makeup session. I also understand that a pattern on my part, of no show or failure to give notice of cancellation, will be discussed with my therapist with regards to current motivation or appropriateness for treatment and may result in a therapeutic discharge and/or referral back to my insurance company. I also understand that there will be additional fees for reports (e.g. for purpose of disability, legal, court, etc.).

I understand that in the case of a *"If this is a life threatening or other emergency"* (as instructed on Mr. Joumas's voice mail) *"I will call 602-494-7110 and ask that I be contacted immediately. After normal office hours please call my service at 480-308-1513 and ask that I be contacted immediately. If they are not able to reach me immediately, please call your referring insurance or managed care company and ask for a Crisis Case Manager and / or call 911."* I understand that many insurance companies require me to call their Crisis Manager if I am unable to reach George Joumas immediately.

I have read and understand the above.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date