

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

(602) 494-7110

Individual, Couple & Family Therapy
Children, Adolescents and Adults
(602) 494-1724 FAX

PERSONAL DATA SHEET

Today's Date: _____

Patient'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

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's name) _____

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 # _____ - _____ - _____

Secondary 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., C.P.C.
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

4545 East Shea Blvd., Suite 112
Phoenix, Arizona 85028
(602) 392-2012 Confidential Voice Mail
www.JoumasConsulting.com

(602) 494-7110

Individual, Couple & Family Therapy
Children, Adolescents and Adults
(602) 494-1724 FAX

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

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

(602) 494-7110

Individual, Couple & Family Therapy
Children, Adolescents and Adults
(602) 494-1724 FAX

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 I may be asked to complete a confidential *SATISFACTION SURVEY* or complete an *OUTCOME MEASURES INVENTORY* to facilitate my therapist maintaining a high level of quality care.

I understand that insurance companies require that my name and identification number be place on every page of my medical record. I prefer that a chart number (i.e.. JG1999125, initials date of intake) 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 \$30.00 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 understand that “*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 602- 787-3190 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

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 _____

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 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
	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.

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

(602) 494-7110

Individual, Couple & Family Therapy
Children, Adolescents and Adults
(602) 494-1724 FAX

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, Joumas Consulting, 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