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**Background Information and Developmental History**

Today’s Date:

Child’s First, Middle and Last Name:

Child’s DOB:

Age:

Sex/Gender/Sexual Orientation:

Ethnicity/Race:

Religion/Spiritual Beliefs:

Current School and Grade:

Child’s primary and secondary language:

Hand child uses for writing or drawing:

Parent/Guardian’s Information (This information is required for insurance billing)

First, Middle and Last Name:

Relationship to the Child:

Gender:

DOB:

Address and Zip Code:

Phone:

E-Mail Address:

Emergency contact if different:

Name of health insurance:

Primary Person Insured (if different from the person above, please provide DOB, address and phone):

Identification #:

Group #:

Employer name on the insurance card:

Social Security # (if using Tricare/Medicare/Medicaid):

Are you seeking written documentation(s) for school or court?:

*\*Please note there are separate fees for preparing written documentations that are not covered by insurance*

Current Concerns:

Past Psychological/Medical Issues:

Current Medications:

Past Medications:

Current treatment besides medication:

Past treatment besides medication:

Child’s current primary care physician (name, address, phone):

Other professionals currently involved in your child’s care:

Present/past drug/alcohol use (if any):

Suicide attempts or violent behavior (if any, ages, reasons, circumstances, how, etc.):

Civil or criminal litigation, lawsuit, or divorce/custody disputes (involving or affecting the child):

People your child currently live with:

Other family or significant people in your child’s life:

Parents’ occupation:

Siblings’, parents’ or other immediate/extended family members’ medical, neurological, psychiatric, learning, behavioral, emotional, developmental or other concerns:

Prenatal/Perinatal History

Were there any complications during pregnancy with the child?

List medications taken during pregnancy, including over the counter drugs.

List the amount and frequency of cigarettes smoked during pregnancy.

List the type, amount and frequency of alcoholic drinks consumed during pregnancy.

List the type, amount and frequency of recreational drugs taken during pregnancy.

|  |  |
| --- | --- |
| At your child’s birth: | |
| Age of the mother |  |
| Age of the father |  |
| Term |  |
| Birth weight |  |
| Apgar scores at 1 and 5 minute |  |
| Were there any complications at birth? |  |

Developmental History

Did you or others have following concerns about your child as a baby?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Excessive crying |  |  |  |
| Difficulty being soothed |  |  |  |
| Problems with sleep |  |  |  |
| Problems with feeding |  |  |  |
| Problems with responsiveness/alertness |  |  |  |
| Failure to thrive/grow |  |  |  |
| Other |  |  |  |

Has there been any concern with the child’s motor skills (e.g., difficulty balancing, walking, running, using pencils, loss of previously acquired skills)?

Has there been any concern with the child’s language development (e.g., speech delay, unclear speech, loss of previously acquired skills)? Does your child use odd phrases, repeats things out of context, speaks with unusual intonation, volume, rhythm, or speed?

Has there been any concern with the child’s ability to use non-verbal gestures (e.g., pointing, nodding, waving), show appropriate facial expressions (e.g., frown, smile), or engage in reciprocal conversation (e.g., asking appropriate questions, adjusting topics of conversations)?

Has there been any concern regarding the ways the child plays or interacts with other children?

Has the child had any problems with vision? If so, has it been corrected?

Has the child had any problems with hearing? If so, has it been treated?

Has the child had problems eating, weight gain, or weight loss?

Has the child had problems with sleep (falling or staying asleep, waking up)?

Has the child had any problems with toilet training?

Does the child currently have any bladder/bowel problems?

Has the child ever experienced the following conditions or injuries?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Asthma |  |  |  |
| Allergies |  |  |  |
| Anemia |  |  |  |
| Frequent cold/flu |  |  |  |
| Bruises easily |  |  |  |
| Snoring or noisy breathing when asleep |  |  |  |
| Ear infection |  |  |  |
| Sustained high temperature |  |  |  |
| Accidental poisoning |  |  |  |
| Head injury/Bumps on the head |  |  |  |
| Coma or loss of consciousness |  |  |  |
| Convulsions/Seizures: |  |  |  |
| Other medical condition or significant illness or injuries |  |  |  |

Has your child ever experienced any of the following difficulties?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Staring in the air |  |  |  |
| Poor eye contact |  |  |  |
| Unusual, restricted facial expression |  |  |  |
| Unusual or lack of responses to light/sound/touch |  |  |  |
| Hobbies/interests that are unusual in their intensity |  |  |  |
| Depressive mood/always sad |  |  |  |
| Withdrawn, isolated, lack of interest |  |  |  |
| Low self-esteem |  |  |  |
| Loses temper |  |  |  |
| Easily frustrated |  |  |  |
| Often irritable, annoyed, or angered |  |  |  |
| Excessive worries/Anxiety |  |  |  |
| Unable to separate from parent |  |  |  |
| Rituals/compulsions |  |  |  |
| Bothered by routine changes |  |  |  |
| Twitching/Tics |  |  |  |
| Memory problems/Forgetful |  |  |  |
| Difficulty sustaining attention |  |  |  |
| Difficulty following directions |  |  |  |
| Avoids tasks that are challenging |  |  |  |
| Elevated level of activity/energy |  |  |  |
| Difficulty remaining seated |  |  |  |
| Excessive talking |  |  |  |
| Difficulty waiting, controlling actions |  |  |  |
| Argues with adults |  |  |  |
| Lies often |  |  |  |
| Physical fights |  |  |  |
| Stealing |  |  |  |
| Cruelty to animals |  |  |  |
| Bullying |  |  |  |
| Relationship difficulties with peers |  |  |  |
| Relationship difficulties with parents |  |  |  |
| Relationship difficulties with siblings |  |  |  |
| Relationship difficulties with other adults (e.g., teachers, relatives) |  |  |  |
| Other |  |  |  |

Has there been any of following changes in your family?

|  |  |
| --- | --- |
| Event | Age (s) |
| Natural disaster |  |
| Move/relocation |  |
| Marital discord |  |
| Separation/Divorce |  |
| Financial problems |  |
| Birth/Adoption of another child |  |
| Parent away or deployed extensively |  |
| Involvement in juvenile court |  |
| Illness or injury of a family member |  |
| Emotional; psychological difficulties of a family member |  |
| Death of a family member, relative or close friend |  |
| Experiencing/Witnessing family violence, abuse, conflict |  |
| Experiencing/Witnessing community violence or war |  |
| Other |  |

How did the event(s) affect your child?

Child’s Academic History (Day Care, Pre-school, Kindergarten, Elementary School, High School)

List the schools your child has attended. Describe concerns raised/accommodation services received. (Please bring in any previous records available).

|  |  |  |
| --- | --- | --- |
| Name of school | Years /Grades Attended | Concerns/Services (if any) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you had any concerns about your child’s performance in the following academic areas?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Reading |  |  |  |
| Writing/Spelling |  |  |  |
| Handwriting |  |  |  |
| Verbal fluency |  |  |  |
| Verbal comprehension |  |  |  |
| Arithmetic/Calculation |  |  |  |
| Math word problems |  |  |  |
| Others |  |  |  |

Has your child ever had previous psychological or neuropsychological testing, either through school or privately? (Please bring in any previous test results available).

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor, psychologist or school | Dates of testing | Tests | Results |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Current Functioning

Is your child currently able to do the following tasks?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Feed self |  |  |  |
| Dress self |  |  |  |
| Bath self |  |  |  |
| Clean own room |  |  |  |
| Help with household chores |  |  |  |
| Other daily activities the child is expected to do |  |  |  |

When your child is disruptive or misbehaves, what steps do you usually take to deal with the problem?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Time out |  |  |  |
| Try to reason |  |  |  |
| Loss of allowance/ privileges |  |  |  |
| Spanking |  |  |  |
| Ignoring |  |  |  |
| Grounding |  |  |  |
| Other |  |  |  |

How does your child usually respond to their behavior corrected or being disciplined?

How does your child get along with his/her parents?

How does your child get along with his/her brothers?

How does your child get along with other children?

How does your child get along with other adults (teachers, relatives, etc.)?

Does your child participate in any extracurricular activities (e.g., organizations, clubs, teams, sports, lessons)?

What are your child’s favorite hobbies, activities, and games?

What are your child’s strengths?

Please provide any other information that may be helpful in understanding your child.

Please describe how your child’s difficulties affected you and other family members.

Please describe what you would like to get out of psychotherapy.