

# Megan F. Gerbracht, Psy.D., LLC

## CHILD BACKGROUND FORM

EXCEPT IN CASES OF CHILD ABUSE OR IMMEDIATE DANGER TO YOUR CHILD, ALL INFORMATION YOU PROVIDE WILL BE KEPT STRICTLY CONFIDENTIAL AND RELEASED ONLY IN ACCORDANCE WITH PROFESSIONAL ETHICS AND APPLICABLE LAW.

### CHILD INFORMATION

CHILD'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

ETHNIC BACKGROUND: \_\_\_\_\_ RELIGION: \_\_\_\_\_

### PARENT(S) INFORMATION

MOTHER'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

ETHNIC BACKGROUND: \_\_\_\_\_ RELIGION: \_\_\_\_\_

MOTHER'S HIGHEST GRADE EDUCATION: \_\_\_\_\_

MOTHER'S OCCUPATION: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE (HOME): \_\_\_\_\_ (WORK): \_\_\_\_\_ (CELL): \_\_\_\_\_

ETHNIC BACKGROUND: \_\_\_\_\_ RELIGION: \_\_\_\_\_

FATHER'S HIGHEST GRADE EDUCATION: \_\_\_\_\_

FATHER'S OCCUPATION: \_\_\_\_\_

PRESENT MARITAL STATUS: \_\_\_ Single \_\_\_ Living together \_\_\_ Engaged  
\_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_ Widowed  
Number of years married/living together: \_\_\_\_\_

Were there any previous marriages for either spouse: \_\_\_\_\_ How many? \_\_\_\_\_

Husband: \_\_\_\_\_ Duration of each: \_\_\_\_\_ Wife: \_\_\_\_\_ Duration of each : \_\_\_\_\_

**WHO IS LIVING IN YOUR RESIDENCE?**

Name:	Age:	Relationship:

**CHILDREN NOT LIVING AT HOME:**

Name:	Age:

**PREVIOUS TREATMENT**

Has any member of your family applied to or been treated at this office before?

NAME(S): \_\_\_\_\_ Approximate Dates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been evaluated or received help at some other agency? \_\_\_\_\_

If yes, where and why?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WHY YOU ARE HERE:**

What is the problem you are seeking help for? How long has it existed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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What might contribute to the problem, i.e., the “emotional climate” in the home or community?

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Please describe any unusual events and/or reactions to events (i.e. prolonged separation from parents, divorce of parents, deaths in family, hospitalization of a family member):

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**DEVELOPMENTAL HISTORY:**

Was this a planned pregnancy? \_\_\_\_\_  
Were there any problems during the pregnancy? \_\_\_\_\_ If yes, what and when? \_\_\_\_\_

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Length of labor? \_\_\_\_\_ Birth difficulties? \_\_\_\_\_

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Breast or bottle fed? \_\_\_\_\_ Any feeding problems during the early years? \_\_\_\_\_ Any feeding problems at present? If yes, what? \_\_\_\_\_

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Any sleep problems during the early years? \_\_\_\_\_ Any sleep problems at present? If yes, what? \_\_\_\_\_

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Child’s health during the first year, including allergies? \_\_\_\_\_

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When did your child achieve the following milestones? Talk \_\_\_\_\_  
Walk \_\_\_\_\_ Toilet Trained \_\_\_\_\_  
Were there any difficulties? \_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY:**

Has your child had any medical problems (i.e.) accidents, high fevers, childhood diseases, surgery, hospitalization)? \_\_\_\_\_ If yes, what and when? \_\_\_\_\_  
\_\_\_\_\_

Child's Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is your child currently taking any medications? \_\_\_\_ If yes, please list,  
Medication(s): \_\_\_\_\_  
Dosage(s): \_\_\_\_\_  
Medicating Physician or Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRE-SCHOOL YEARS:**

Relationship with brothers and sisters: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship with friends: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SCHOOL YEARS:**

Age when started Kindergarten: \_\_\_\_\_

School performance – academic: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School performance – social: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Overall, how does your child feel about school at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

