MEGAN F. GERBRACHT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST
1489 CHAIN BRIDGE ROAD, SUITE 203 MCLEAN, VIRGINIA 22101

Child and Adolescent Background Form

Date Completed: _________________ Referred By: ______________________________

CHILD'S INFORMATION:
Child's Name:____
Age: ___________________________ D.O.B.: ______________________________
School: ____
Grade: ___________________________ Teacher: ____________________________
Ethnic Background: ________________ Religion: ____________________________

PARENT(S) INFORMATION:
1. Parent's Name: _____________________________________Age:_________________
Address: ____
Phone - Home: ________________ Work: ________________ Cell: ________________
E-mail Address:____
Ethic Background: _________________________ Religion: _________________________
1. Parent's Highest Level of Education:____
1. Parent's Occupation:____

2. Parent's Name: _____________________________________Age:_________________
Address: ____
Phone - Home: ________________ Work: ________________ Cell: ________________
E-mail Address:____
Ethic Background: _________________________ Religion: _________________________
2. Parent's Highest Level of Education:____
2. Parent's Occupation:____

Parents' Relationship Status: □ Married □ Never Married □ Separated □ Divorced
□ Partnered □ Widowed □ Other: ____

Were there any previous marriages for either spouse: ______ If yes, provide more detail:
Parent 1: _____ Duration of each: ______ Parent 2: _____ Duration of each: ________

Who is living with your child (family, step/half siblings, family friends, extended family, etc.)?

Name:	Age:	Relationship:

Are there children not living at home? ___________ If yes, provide more detail below:

Name:	Age:	Location:

PREVIOUS TREATMENT:

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

Name(s): ________________________ Approx. Dates: ________________________

________________________________ ________________________________

Has your child been evaluated or received help at some other agency? _______________

If yes, provide more detail below:

Location/Provider: ____

Type/Duration of Service:____

Has your child received a diagnosis/diagnoses?

Medical: ____

Academic: ____

Mental Health: ____

Other: ____

WHY YOU'RE HERE:

Concerns about your child:

- ☐ Behavior at school/home
- ☐ Eating
- ☐ Sleeping
- ☐ Sadness/depression
- ☐ Suicidal thoughts
- ☐ Self-harm behaviors
- ☐ Worries/shyness
- ☐ Anger/irritability
- ☐ Academic performance/grades
- ☐ Difficulty paying attention
- ☐ Peer relationships
- ☐ Health
- ☐ Drugs/alcohol
- ☐ Sexual behavior

Other: ____

Provide more detail about the current problem(s), including duration of existence:

____

____

____

____

What might contribute to the problem, i.e. the "emotional climate" at home, school, or in the community?

____

____

____

Revised: 3/2016

Significant Life Events:
- ☐ Death of a loved one (If so, state name(s): ________________________________)
- ☐ Move/School change
- ☐ Loss of significant friendship (If so, state name(s): ________________________)
- ☐ Financial problems for family
- ☐ Parental separation/divorce
- ☐ Parental remarriage/new step-siblings
- ☐ Birth of a new sibling
- ☐ Legal problems for family member
- ☐ Trauma (violence, natural disaster, car accident, etc.)
- ☐ Hospitalization of self or other (If so, provide more detail: __________________ ____)
- ☐ Other: ____ ____

Child's Strengths or Abilities:
- ☐ Academic/grades
- ☐ Sports
- ☐ Creative (art, music, etc.)
- ☐ Group involvement (clubs, organizations, etc.)
- ☐ Religious involvement
- ☐ Sense of humor
- ☐ Care of others
- ☐ Other: ____________________________ ____________________________

DEVELOPMENTAL HISTORY:

☐ Parental Pregnancy ☐ Adoption ☐ Donor Conception ☐ Other: _______________

If parental pregnancy, were there any problems during the pregnancy?

____
____
____

Was your child breast or bottle fed? _____________Any feeding problems during the early years? __________Any feeding/ eating problems at present? If yes, please explain:

____
____

Was this a planned pregnancy? ☐ Yes ☐ No

If adopted, where was your child adopted from?

☐ Domestic (From: ________________) ☐ International (From: _______________)

Information about adoption: ____

____
____

If donor conception, please provide more information:

____
____
____

Developmental problems with:

- ☐ Eating
- ☐ Sleeping
- ☐ Sitting up
- ☐ Walking
- ☐ Talking
- ☐ Toileting
- ☐ Bedwetting
- ☐ Writing letters or using scissors
- ☐ Reading or letter identification
- ☐ Physical coordination (running, jumping, climbing)
- ☐ Sensory sensitivities (touch, sound, light, motion, etc.)
- ☐ Responding to discipline or behavior management
- ☐ Anger/temper tantrums
- ☐ Fears, phobias, or shyness
- ☐ Sexualized play
- ☐ Other:______________________ ____________________________

CHILD'S MEDICAL HISTORY:

- ☐ Medical problems during pregnancy
- ☐ Maternal drug or alcohol use during pregnancy
- ☐ Premature birth (If so, weight at birth: ______________ Gestational age: ________)
- ☐ Complications during birth (i.e. Emergency C-section, low oxygen, etc.)
- ☐ Neonatal intensive care (If so, how long? _________________________________)
- ☐ Health problems as newborn or toddler (If so, provide more detail: _____________ ____)
- ☐ Frequent ear infections
- ☐ History of Strep infections
- ☐ Asthma or allergies (If so, provide more detail: _____________________________ ____)
- ☐ Head injuries, concussions, seizures (If so, provide more detail: _______________ ____)
- ☐ Surgeries (If so, provide more detail: ______________________________________ ____)
- ☐ Hospitalizations (If so, provide more detail: _________________________________ ____)
- ☐ (If applicable) Has menses begun?______________ Age of onset?_____________
- ☐ Other: ____

Pediatrician's Name: ____

Phone Number: ____

Is your child taking any medications? __________ If yes, please list below:

Medication Name:	Dosage:

Medicating Physician or Psychiatrist:_______________________ Phone:_____________

FAMILY HISTORY:

Has anyone in your family struggled with (treated or untreated):

- ☐ Anxiety
- ☐ Depression
- ☐ Developmental disabilities (Autism Spectrum Disorder, Intellectual Disabilities, etc.)
- ☐ Hallucinations or delusional thinking patterns
- ☐ Learning problems (reading, math, spelling, etc.)
- ☐ Attention problems
- ☐ Disordered eating issues (obesity, anorexia, bulimia, etc.)
- ☐ Excessive alcohol or drug use
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Suicide attempts or completed suicide
- ☐ Other:_____________________
  ____

Has anyone ever expressed concern about the ways in which anger is managed in your family? If yes, please explain or give example (s).

____
____
____

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, punching. If yes, please explain:

____
____
____

Has anyone in your family ever expressed concern about another family member's use of alcohol or drugs? Please Explain.

____
____
____

Does anyone in the family regularly: (if so, how much or how often?)

Drink:________________________________ Smoke:________________________________

Use prescribed or non-prescribed drugs?____

If so, does their habit hurt their relationships with others? ______________________

RELATIONSHIP HISTORY:

Relationship with parents and/or other caregivers: _________________________________

____
____

Relationship with brothers and/or sisters: ____

____
____

Peer Relationships:

Does your child have a friend or friends outside the family? ☐ Yes ☐ No

Do you know them? ☐ Yes ☐ No

Do his/her friends tend to be: ☐ Older ☐ Younger ☐ About the same age as your child

How well does your child get along with others?

____

____

SCHOOL:

When did your child start school? ____

Schools attended:

____

____

Has your child:

- ☐ Repeated a grade
- ☐ Skipped school
- ☐ Been suspended
- ☐ Been expelled
- ☐ Stopped completing homework
- ☐ Experienced bullying
- ☐ Been aggressive at school: ☐ Verbal ☐ Physical
- ☐ Received an IEP or 504 plan
- ☐ Received any special services: ☐ OT ☐ SLP ☐ PT ☐ Reading ☐ Self-Contained ☐ Behavior
- ☐ Other: ______________________________ ______________________________

School Performance – Academic: ____

____

____

School Performance – Social: ____

____

____

Name of person who completed form: ____

Relationship to child: ___________________________________Date: __________________

In case of an emergency, whom can we notify?

Name: ___________________________________**Relationship:** ____________________________

Phone - Home: ____________________**Work:** ____________________**Cell:**______________________

THANK YOU!

Revised: 6/2016