



Child & Adolescent Gifted Intake

Person Completing Form: _____ Date: _____

Your relationship to child: _____

Are you this child's legal guardian? Yes No

If **No**, Please Explain: _____

Child Information

Name of Child: _____

What does this child like to be called? _____ Female Male

Date of Birth: ____ / ____ / ____ Age: ____ Phone: (____) ____ - ____

Home Address: _____

School: _____ Teacher: _____ Grade: _____

School Phone: (____) ____ - ____

School Address: _____

Where was the child born? _____ How long has the child lived in the USA? _____

Language(s) spoke in home? _____

Language most often spoken **TO** the child? _____ Language most often spoken **BY** the child? _____

Parent Information

Mother's Name: _____

Father's Name: _____

Biological Adopted Step Foster Other _____

Biological Adopted Step Foster Other _____

Address: Same as above

Address: Same as above

Contact Information: Ok to contact

Phone: (H) (____) ____ - ____ Best

(W) (____) ____ - ____ Best

(C) (____) ____ - ____ Best

Email: _____ Best

Contact Information: Ok to contact

Phone: (H) (____) ____ - ____ Best

(W) (____) ____ - ____ Best

(C) (____) ____ - ____ Best

Email: _____ Best

With whom does this child live? _____

Sibling Information

Please list all brothers and sisters of this child:

Name of Sibling	Age	Brother or Sister		Living at home	
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Yes	<input type="checkbox"/> No

How does your child get along with family members? _____

How is your child disciplined? _____

How does your child get along with same-aged peers/ friends? _____

List any behavioral or social-emotional concerns you may have regarding your child. _____

Has your child ever experienced any major stressors or trauma? Yes No If no, explain: _____

What are your child's interests/hobbies? _____

What are your child's major strengths and positive traits? _____

Medical Information

Name of Pediatrician: _____ Phone: (____) _____ - _____

Address: _____

Are there other health professionals involved with this child? Yes No

If yes, please provide their names, specialties, contact information, and reasons why this child is seeing them.

1. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

2. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

3. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

4. Name: _____ Specialty: _____ Phone: (____) _____ - _____

Reason: _____

Did this child experience any serious injuries, illnesses or hospitalizations? Yes No Not Sure

If yes or not sure, please explain including incident, age, and outcome:

Has this child ever sustained a head injury, lost consciousness, had a concussion and/or been in a coma? Yes No Not Sure

If yes or not sure, please explain including incident, age, and outcome: _____

Please list any medications this child is taking and for what reason: _____

Does your child wear glasses? Yes No Date of last exam: ____ / ____ / ____

Does your child wear a hearing aid? Yes No Date of last exam: ____ / ____ / ____

Does your child receive speech/language services, and/or is their cause for concern? Yes No

Birth & Development

Were there any complications that occurred during the pregnancy of this child? Yes No

If yes, explain: _____

Were there any complications that occurred during the birth of this child? Yes No

If yes, explain: _____

Did this child experience any developmental delays; i.e., crawling, walking, speaking, motor movement, etc.? Yes No Not Sure

If yes or not sure, please explain including incident, age, and outcome: _____

Mental Health History

Has this child ever been under the care of a mental health professional; i.e., psychiatrist, psychologist, social worker, counselor, etc.? Yes No

If yes, explain: _____

Has this child ever had a psychiatric or psychological evaluation? Yes No

If yes, please provide the following information:

Who conducted the evaluation? _____

When was it conducted? _____

For what reason? _____

Do you have a copy of the evaluation/report? Yes No

What was the outcome of the evaluation? _____

Educational History

List all schools your child has attended (include pre-school if applicable):

<u>Name of School</u>	<u>Location</u>	<u>Grades</u>	<u>Reason for Leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Age student started kindergarten _____ Repeated a grade? Yes No
If yes, what grade? _____ Why? _____

Has your child ever been excessively absent from school (more than 15 days in one school year)? Yes No
If yes, what grade? _____ Why? _____

What are your child's feelings towards school? _____

What do you consider to be your child's major academic weaknesses/strengths? _____

What is your child's behavior like in school? _____

To the best of my knowledge, the information completed on this intake is accurate. I give my consent for you to communicate with this child, this child's doctors and other health professionals for the purpose of coordinating professional services. I understand that I may withdraw this consent by written notice to you at any time.

Signature of Parent or Guardian

Date