

Gifted Questionnaire

The following questions are asked so that we can better understand your child. This type of information is very helpful in making an accurate diagnosis and providing recommendations. Please read the questions carefully and answer as fully as possible. Please print clearly. We will have the opportunity to discuss these questions in detail at the time of your appointment. Thank you.

PLEASE PRINT

DATE _____ CHILD'S NAME _____

BIRTHDATE _____ AGE _____ GRADE _____

PERSON COMPLETING FORM _____

RELATIONSHIP TO PATIENT _____

CHILD'S HOME ADDRESS _____

HOME PHONE _____ ALT PHONE _____

PREFERRED EMAIL ADDRESS _____

ARE YOU THE CHILD'S LEGAL GUARDIAN? YES NO

IF NO, PLEASE GIVE NAME OF GUARDIAN _____

GUARDIAN'S PHONE NUMBER _____

PARENT'S MARITAL STATUS _____ HOW LONG? _____

REFERRED BY:

PEDIATRICIAN/PCP:

ADDRESS:

ADDRESS:

PHONE: _____

PHONE: _____

What questions do you have that you hope this evaluation will answer? _____

Has your child ever been previously evaluated?

YES _____ NO _____ If yes, please explain (**Please bring a copy of all reports to the evaluation**):

Has any other family members (i.e., mother, father, brother, sister, aunt, uncle, etc.) been identified as “gifted” or do any possess any notable talents? YES _____ NO _____ If yes, please explain:

Describe the best things about your child: _____

Describe your child socially (temperament, friends, fights, popularity, participation, etc.): _____

Does your child have any special interests or talents? _____

Does your child play any musical instruments or play any sports? _____

Is your child involved with any community or religiously based activities or clubs, volunteer work or community service? _____

DEVELOPMENTAL HISTORY:

Check all that apply to describe the birth of this child:

- | | | |
|---|--|--|
| <input type="checkbox"/> spontaneous delivery | <input type="checkbox"/> breech presentation (feet 1 st) | <input type="checkbox"/> normal presentation |
| <input type="checkbox"/> induced delivery | <input type="checkbox"/> Cesarean section (C-section) | <input type="checkbox"/> use of Pitocin |
| <input type="checkbox"/> forceps used | <input type="checkbox"/> premature delivery(____ weeks) | <input type="checkbox"/> late delivery (____ weeks) |
| <input type="checkbox"/> hemorrhage | <input type="checkbox"/> multiple births (e.g. twins) | <input type="checkbox"/> fetal distress |
| <input type="checkbox"/> general anesthesia | <input type="checkbox"/> local anesthesia (epidural/spinal) | <input type="checkbox"/> duration of labor(____ hours) |

_____ muscle relaxant _____ pain medication _____ spontaneous delivery

Were there any problems with labor and delivery? YES ___ NO ___ If yes, please explain: _____

PERINATAL HISTORY:

Please describe your child as an infant and toddler (level of activity, personality, sleeping, naps, eating, etc.).

DEVELOPMENTAL MILESTONES: (Please provide the **approximate ages** for each milestone)

Crawled: _____	First syllables ("ma ma"): _____
Took first steps: _____	First words: _____
Walked alone: _____	2-3 Word Phrases (e.g. "go bye-bye"): _____
Rode bicycle: _____ (without training wheels)	Complete Sentences: _____
	Toilet Training (Day): _____ Night: _____

CHILD'S PRESENT MEDICAL STATUS

Current Health: _____ (Please rate poor, fair, good, excellent, etc.)

Child's present height: _____ weight: _____

Is your child in any way physically ill at this time? YES ___ NO ___ If yes, please explain and specify if your child is currently being treated for this illness: _____

Please list any medication your child is currently taking:

<u>Medication</u>	<u>Dose</u> (e.g. 20mg four times a day)	<u>Date Started</u>
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Is your child currently involved in any type of professional mental health treatment (i.e., psychotherapy, family counseling, etc.)? YES _____ NO _____ If yes, please list:

<u>Clinic</u>	<u>Date(s) seen</u>	<u>Contact Person</u>	<u>Phone Number</u>
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EDUCATION:

Name of Current School: _____

Home School District: _____

School Address: _____

Current Grade Placement: _____

Classroom Type (i.e., regular, advanced placement, resource room, etc.): _____

Teacher's Name: _____

Principal's Name: _____

School Psychologist or Counselor: _____

Please list the name(s), addresses and phone numbers of any other persons involved in your child's education whom you feel we should contact:

Has your child attended any other schools? YES _____ NO _____ If yes, please list: _____

Did your child attend a preschool program? YES _____ NO _____ If yes, what type of program, at what age did he/she begin, and how often (i.e., nursery school, age 4, 2 times per week, 3-hour sessions): _____

At what age did your child begin to read on his/her own (not just being able to identify words)? _____

Does your child currently receive special services? YES _____ NO _____ If yes, specify type (i.e., challenge, enrichment, self-contained class, resource room, reading or math lab, etc.):

Occupation: _____

Current place of employment: _____

Were you ever in any type of special education class (including gifted classes)? YES___ NO___ If yes, please explain: _____

Please use this space for any additional information/comments you wish to share with us about your child:
