CALIFORNIA STATE UNIVERSITY, LONG BEACH
COMMUNITY CLINIC FOR COUNSELING AND EDUCATIONAL SERVICES
1250 Bellflower Boulevard, ED2-155
Long Beach, CA 90840
(562) 985-4991

Youth Transition Planning Application
Information Questionnaire

All information will be treated with strict confidentiality

Date: ________________________________

Name: ___________________________________ Current Grade: _________________

Date of Birth: ________________________ Age:________ Sex: ☐ Male ☐ Female

Racial/ethnic background: ____

Primary language spoken at home: ___________________ Secondary language: _______________________

Home address: ____
(Street) (City) (Zip code)

Home phone: (______) ______________________ Email:____

Parent/Guardian name: ____________________________ Relationship:________________________

Cell phone: (________) ______________________ Legal Guardian? ☐ Yes ☐ No

Parent/Guardian name: ____________________________ Relationship: __________________

Cell phone: (________) ______________________ Legal Guardian? ☐ Yes ☐ No

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For Office Use Only

☐ Notice of application received: ______ Notes: ____

☐ Reviewed for: __________________ ☐ Confirmed ☐ Waitlisted ☐ Not Accepted Date called:________ ☐

☐ Reviewed for: __________________ ☐ Confirmed ☐ Waitlisted ☐ Not Accepted Date called:________ ☐

☐ Reviewed for: __________________ ☐ Confirmed ☐ Waitlisted ☐ Not Accepted Date called:________ ☐

☐ Reviewed for: __________________ ☐ Confirmed ☐ Waitlisted ☐ Not Accepted Date called:________ ☐

Name, age, and relationship of persons living with you:

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for Referral

How did you hear about the Clinic? _____

Please describe reason(s) you are seeking services at the Community Clinic.

_____

_____

Have you received services at this Clinic before? ☐ Yes ☐ No

Name of person completing questionnaire: _____

Relationship: _____

Health & Development

Do you have any developmental disabilities (e.g., intellectual disability, autism, etc.)?
_____No _____Yes (continue below)

Please describe: _____

Do you have difficulty with your hearing or vision? No _____Yes (continue below)

Please describe: _____

Do you take any medications regularly? ___No _____Yes (continue below)

Please describe: _____

Do you have any allergies? _____No _____Yes (continue below)

Please describe: _____

Are there any other health impairments to be aware of? _____No _____Yes (continue below)

Please describe: _____

Academic Information

PLEASE INCLUDE A COPY OF THE FOLLOWING DOCUMENTS:

- **A copy of your most recent report card**
- **A copy of your most recent IEP and Transition Plan**
- **A copy of your most recent psychoeducational evaluation**

School name: _____ District: _____

Current grade: _____ Current classroom/program placement: _____

Are you currently receiving specialized services (i.e., speech and language, counseling, etc.) at your school?
_____No _____Yes (please describe): _____

Are you currently enrolled in any services (e.g., tutoring, counseling) outside of school?
_____No _____Yes (please describe): _____

Please rate your skills in the following transition areas:

	Well prepared	**Somewhat prepared**	**Currently working on**	**Not at all prepared**
Career exploration and preparation	1	2	3	4
Independent living skills	1	2	3	4
Continuing education and training	1	2	3	4
Recreation	1	2	3	4
Community participation	1	2	3	4
Interpersonal relationships	1	2	3	4
Self-determination	1	2	3	4
Agency collaboration	1	2	3	4
Mental health	1	2	3	4