CALIFORNIA STATE UNIVERSITY, LONG BEACH
COMMUNITY CLINIC FOR COUNSELING AND EDUCATIONAL SERVICES
1250 Bellflower Boulevard, ED2-155
Long Beach, CA 90840
Tele: (562) 985-4991
Fax: (562) 985-1469

Youth Application
Information Questionnaire

All information will be treated with strict confidentiality

Date: _____

Clinic services requested:

- ☐ Psychoeducational Assessment (offered spring semester only)
- ☐ Individual Counseling (offered fall & spring semester)
- ☐ Summer Math Clinic
- ☐ Intensive Academic Intervention:
  In which academic areas do you wish to have tutoring?
  ☐ Reading ☐ Writing ☐ Math/Algebra ☐ Other _____

Name of child: _____ Current Grade: _____

Date of Birth: _____ Age:_____ Sex: ☐ Male ☐ Female ☐ Non-Binary

Racial/ethnic background: _____

Primary language spoken at home: _____ Secondary language: _____

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

Home phone: (_____) _____ Email:_____

Would you like to sign up for our email update? ☐ Yes ☐ No

Parent/Guardian name: _____ Relationship to child:_____

Cell phone: (_____) _____ Legal Guardian? ☐ Yes ☐ No

Parent/Guardian name: _____ Relationship to child: _____

Cell phone: (_____) _____ Legal Guardian? ☐ Yes ☐ No

Are the above parents: ☐ Married/Domestic Partners ☐ Separated ☐ Divorced ☐ Other_____

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 in the child's home:

Name:	Age:	Relationship to Child:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for Referral

1. How did you hear about the Community Clinic? _____
2. Please describe the reason(s) you are seeking services at the Community Clinic._____

_____

3. Has the child previously received services at the Community Clinic? ☐ No ☐ Yes (continue below)
    a. If yes, services received and date: _____
4. Name of person completing questionnaire: _____
    a. Relationship to the child: _____

Health and Developmental History

5. Has the child ever been diagnosed with a disability? ☐No ☐Yes (continue below)
    a. Name of disability (e.g., autism, learning disability, etc.):_____
    b. Age/grade child was diagnosed with the disability: _____
    c. Who diagnosed the child as having the disability (e.g., pediatrician, IEP team, etc.)? _____
6. Does the child have difficulty with their hearing or vision? ☐No ☐Yes (continue below)
    a. Please describe: _____
7. Does the child take any medication(s) regularly? ☐No ☐Yes (continue below)
    a. Please describe: _____
8. Does the child have any allergies? ☐No ☐Yes (continue below)
    a. Please describe: _____
9. Are there any health concerns? ☐No ☐Yes (continue below)
    a. Please describe: _____

Academic Information

PLEASE INCLUDE A COPY OF THE FOLLOWING DOCUMENTS:

- **A copy of the child's most recent report card**
- **A copy of the child's most recent performance on state assessments (i.e., CAASPP report)**

Your application cannot be reviewed without a recent copy of the above documents.

1. School name: _____
2. District: _____
3. Current grade: _____
4. Does the child currently receive special education services at school? ☐No ☐Yes (continue below)
   a. Special education services receiving (mark all that apply):

      ☐ Resource Specialist ☐ Speech-Language ☐ Counseling ☐ Adapted P.E.

      ☐ Assistive Technology ☐ Occupational Therapy ☐ Other: _____

   b. Setting in which the child receives the majority of their instruction at school:

      ☐ General Education Classroom ☐ Special Day Class (SDC) ☐ Collaborative Classroom
5. Has the child ever been retained? ☐No ☐Yes,_____grade
6. Has the child ever skipped a grade? ☐No ☐Yes,_____grade
   a. Please explain the reasons for retention or skipping:_____
7. Has the child even been assessed for a disability at school and found not eligible to receive special education services? ☐No ☐Yes (continue below)
   a. Assessment date: _____ Results: _____
8. Is the child currently receiving any specialized services (not including special education services) at school (e.g., counseling, Tier 2 academic services, behavior plan or contract, 504 accommodations?
   ☐No ☐Yes (continue below)
   a. Please describe: _____
9. Is the child currently receiving services (e.g., tutoring, counseling) outside of school?
   ☐No ☐Yes (continue below)
   a. Please describe: _____

10. Please list and describe the school subjects the child is currently experiencing difficulty:

	SUBJECT	DESCRIPTION OF THE CHILD'S PERFORMANCE
a.	_____	_____
b.	_____	_____
c.	_____	_____

Behavioral History

11. Please circle the most appropriate response to the following items.

My child has difficulty in the following areas at school:

Following oral instructions	☐often	☐sometimes	☐rarely	☐not sure
Following written instructions	☐often	☐sometimes	☐rarely	☐not sure
Recalling learned material	☐often	☐sometimes	☐rarely	☐not sure
Completing class assignments	☐often	☐sometimes	☐rarely	☐not sure
Completing homework	☐often	☐sometimes	☐rarely	☐not sure
Maintaining a study schedule	☐often	☐sometimes	☐rarely	☐not sure
Staying on-task in class	☐often	☐sometimes	☐rarely	☐not sure
Participation in class discussions	☐often	☐sometimes	☐rarely	☐not sure
Academic self-confidence	☐often	☐sometimes	☐rarely	☐not sure
Staying motivated	☐often	☐sometimes	☐rarely	☐not sure
Cooperating with others	☐often	☐sometimes	☐rarely	☐not sure
Maintaining friendships	☐often	☐sometimes	☐rarely	☐not sure
Frequent disciplining	☐often	☐sometimes	☐rarely	☐not sure

12. Please check any of the following behaviors that are regularly exhibited by the child at home:

☐ Temper tantrums	☐ Extreme fears	☐ Lying
☐ Jealousy/resentment	☐ Stealing	☐ Easily frustrated
☐ Low self-esteem	☐ Low motivation	☐ Overly aggressive
☐ Tired/fatigued	☐ Extremely active	☐ Easily distracted
☐ Eating problems	☐ Depression	☐ Impulsive
☐ Anxiety and/or panic attacks		

☐ Other: _____

a. Describe the nature of any behaviors checked above (situations where the behavior is observed, how it impacts daily activities, etc.) :

b. What strategies have been used to resolve the above behaviors at home and/or school? How successful are these strategies:

13. Are any of the following concerns applicable to your child?

Suicidal thoughts	☐ Yes	☐ No
Substance use/abuse	☐ Yes	☐ No
Eating disorder	☐ Yes	☐ No

a. Please describe the nature of any concerns checked above:

14. Briefly describe the child's relationship with teachers:

15. Briefly describe the child's relationship with peers:

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Teacher Report Form

Date_____

Child's Name_____ Date of Birth_____

Parent/guardian Instructions

Please sign the AUTHORIZATION TO RELEASE INFORMATION at the bottom of this form and give it to your child's teacher to complete.

AUTHORIZATION TO RELEASE INFORMATION

I hereby grant permission for the exchange of information regarding my child's academic performance and social/emotional adjustment including final reports between the Community Clinic for Counseling and Educational Services at California State University, Long Beach and my child's school.

_____ _____
Parent/Guardian Name (please print) Parent/Guardian Signature

_____
Date

Teacher Instructions

You have been identified as a helping professional who is familiar with the academic and behavioral performance of the above mentioned child who has been referred to us for assistance. Please take a few moments to complete the following questionnaire. Your comments will be extremely helpful for the clinicians working with this child. A parent release for the exchange of information can be found above. Please return this completed questionnaire within 7 days to the parent/guardian or to the Clinic in the self-addressed return envelope.

_____ _____
Teacher name (please print) Teacher Signature

_____
Date

<u>Teacher Instructions:</u> Please rate the student's skills in the following areas relative to other students in your classroom:

	1 **Far below average** **2+ years below grade level**		**3** **Average** **At grade level**		**5** **Far above average** **2+ years above grade level**
Reading Skills	1	2	3	4	5
Writing Skills	1	2	3	4	5
Math Skills	1	2	3	4	5
Social/Emotional Skills	1	2	3	4	5

Please include any comments on your ratings:_____

_____

_____

_____

_____

_____

Please report any quantitative data on the student's academic skills (i.e., curriculum-based assessments, teacher assessments, math facts, etc.)

_____

_____

_____

If you were to pick one skill to improve upon for this student, what would it be? Why?

_____

_____

_____

_____