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

Early Childhood Clinic
Information Questionnaire

All information will be treated with strict confidentiality

Date: ________________________________

Name of child: __________________________________ Grade: ☐ Pre-K ☐ Kindergarten

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:____

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____________

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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:______

☐ 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

How did you hear about the Clinic? ____

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

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Has the child received services at this Clinic before? ______No ______Yes

Name of person completing questionnaire: ______________________________________

Relationship to the child: ____

Health & Development

Does the child have any developmental disabilities (e.g. intellectual disability, autism, etc.)?
______No ______Yes (continue below)

Please describe: ____

Does the child experience difficulty with his/her hearing or vision? ______No ______Yes (continue below)

Please describe: ____

Does the child have a learning disability? _________No ______Yes (continue below)

Please describe: ____

Does the child take any medication regularly? _____No ______Yes (continue below)

Please describe: ____

Does the child 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

Does your child attend preschool? ________No ______Yes (continue below)

How many days does your child attend preschool a week? ____________________________________

How many hours each day? ____

Preschool name: ____

Preschool address: ____

Preschool phone number: (_________) ______________________________

Is your child currently receiving specialized services within or outside of preschool (speech and language, physical therapy, counseling, etc.)? _______No ______Yes (continue below):

If so, what is the nature of these services (type of service, areas of concern)? ______________________________

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Do you or your child's teacher have any concerns regarding your child's pre-academic, social, or communications skills? _____No ______Yes (continue below):

If so, please explain: ____

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Behavioral History

Please circle the most appropriate response to the following items.
My child has difficulty in the following areas at home and/or at school:

Following oral directions	yes	no	sometimes	not sure
Initiating play with others	yes	no	sometimes	not sure
Maintaining play with others	yes	no	sometimes	not sure
Cooperating with others	yes	no	sometimes	not sure
Displaying appropriate social skills	yes	no	sometimes	not sure
Getting into trouble at school or during other structured times/activities	yes	no	sometimes	not sure

Briefly describe the child's relationship with her/his teachers: ______________________________

____

Briefly describe the child's relationship with her/his peers: ______________________________

____

Please check if any of the following behaviors are regularly exhibited by the child:

- ☐ Temper tantrums
- ☐ Jealousy/resentment
- ☐ Low self-esteem
- ☐ Tired/fatigued
- ☐ Eating problems
- ☐ Extreme fears
- ☐ Stealing
- ☐ Daydreaming
- ☐ Hyperactivity
- ☐ Depression
- ☐ Lying
- ☐ Easily frustrated
- ☐ Overly aggressive
- ☐ Easily distracted
- ☐ Impulsivity
- ☐ Other: ____

Please comment on any of the checked items: ______________________________

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What strategies have been used in attempt to resolve these behaviors? ______________________________

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