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: _____

Please check the Clinic services that you are interested in:

- ☐ Psychoeducational Assessment (offered Spring semester only)
- ☐ Individual Counseling (offered Fall & Spring semester)
- ☐ 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

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

How did you hear about the Clinic? _____

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

Has the child received services at this Clinic before? ☐ Yes ☐ No

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: _____

Does the child experience difficulty with sustaining attention and/or controlling impulses? ☐ No ☐ Yes

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 the child's most recent report card**
- **A copy of the child's most recent state standardized test scores (i.e. CST report)**
- **Your application cannot be reviewed without a recent copy of these documents.**

School name: _____ District: _____

Current grade: _____ Current classroom placement: ☐ General education ☐ Special education

Has the child ever been retained? ☐ No ☐ Yes, _____ grade

Has the child ever skipped a grade? ☐ No ☐ Yes, _____ grade

Please explain the reasons for retention or skipping:

Has the child been assessed for learning disabilities? ☐ No ☐ Yes (continue below)

Date assessed: _____ Results:

Is the child currently receiving specialized services (i.e. RSP, speech and language, counseling, etc.) WITHIN school? ☐ No ☐ Yes (please describe): _____

Is the child currently enrolled in services (e.g. tutoring, counseling) OUTSIDE of school? ☐ No ☐ Yes (please describe): _____

Please list the school subjects the child is experiencing difficulties with and provide a brief explanation.

	SUBJECT	**DESCRIPTION OF THE CHILD'S PERFORMANCE**
1.	_____	_____
2.	_____	_____
3.	_____	_____

Behavioral History

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

Briefly describe the child's relationship with teachers:

Briefly describe the child's relationship with peers:

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

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

☐ Other: _____

Please comment on any of the checked items:

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

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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 of a similar age and grade level:

	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 students academic skills (i.e. percentile/standard scores from STAR, curriculum based assessments, running records, math facts, etc.)

_____

_____

_____

If you were to pick one skill we could help the student improve, what would it be? Why?

_____

_____

_____

_____