

**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: \_\_\_\_\_

<input type="checkbox"/> Reviewed for: _____	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Waitlisted	<input type="checkbox"/> Not Accepted	Date called: _____	<input type="checkbox"/>
<input type="checkbox"/> Reviewed for: _____	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Waitlisted	<input type="checkbox"/> Not Accepted	Date called: _____	<input type="checkbox"/>
<input type="checkbox"/> Reviewed for: _____	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Waitlisted	<input type="checkbox"/> Not Accepted	Date called: _____	<input type="checkbox"/>
<input type="checkbox"/> Reviewed for: _____	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Waitlisted	<input type="checkbox"/> Not Accepted	Date called: _____	<input type="checkbox"/>

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	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Following written instructions	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Recalling learned material	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Completing class assignments	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Completing homework	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Maintaining a study schedule	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Staying on-task in class	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Participation in class discussions	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Academic self-confidence	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Staying motivated	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Cooperating with others	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Maintaining friendships	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure
Frequent disciplining	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> rarely	<input type="checkbox"/> not sure

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Temper tantrums     | <input type="checkbox"/> Extreme fears    | <input type="checkbox"/> Lying             |
| <input type="checkbox"/> Jealousy/resentment | <input type="checkbox"/> Stealing         | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Low self-esteem     | <input type="checkbox"/> Low motivation   | <input type="checkbox"/> Overly aggressive |
| <input type="checkbox"/> Tired/fatigued      | <input type="checkbox"/> Extremely active | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Eating problems     | <input type="checkbox"/> Depression       | <input type="checkbox"/> Impulsive         |
| <input type="checkbox"/> Other: _____        |   |  |

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

\_\_\_\_\_

\_\_\_\_\_

13. Briefly describe the child's relationship with teachers: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

**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  
**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

**Teacher Instructions:** Please rate the student's skills in the following areas relative to other students in your classroom:

	<b>1</b> <b>Far below average</b> <b>2+ years below grade level</b>		<b>3</b> <b>Average</b> <b>At grade level</b>		<b>5</b> <b>Far above average</b> <b>2+ years above grade level</b>
--	---	--	---	--	---

<b>Reading Skills</b>	1	2	3	4	5
-----------------------	---	---	---	---	---

<b>Writing Skills</b>	1	2	3	4	5
-----------------------	---	---	---	---	---

<b>Math Skills</b>	1	2	3	4	5
--------------------	---	---	---	---	---

<b>Social/Emotional Skills</b>	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?

---

---

---

---