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

Are the above parents: † Ma

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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:_____

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? _____ 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)? _____

_____

_____

_____

_____

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: _____

_____

_____

_____

_____

_____

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
- † Other: _____
- † Extreme fears
- † Stealing
- † Daydreaming
- † Hyperactivity
- † Depression
- † Lying
- † Easily frustrated
- † Overly aggressive
- † Easily distracted
- † Impulsivity

Please comment on any of the checked items: _____

_____

_____

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

_____

_____

_____