

CALIFORNIA STATE UNIVERSITY, LONG BEACH
COMMUNITY CLINIC FOR COUNSELING AND EDUCATIONAL SERVICES
1250 Bellflower Boulevard, ED255
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 I _____ MC SrtF5-(_____) -D 7 >>ent I _____ 5450.

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: _____

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

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Teacher Instructions: Please rate the student's skills in the following areas relative to other students of a similar age and grade level:

	1		3		5
	Far below average		Average		Far above average
	2+ years below grade level		At grade level		2+ years above grade level

Reading Skills	1	2	3	4	5
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Writing Skills	1	2	3	4	5
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Math Skills	1	2	3	4	5
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Social/Emotional Skills	1	2	3	4	5
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Please include any comments on your student: