

NAME: _____

YOUTH INFORMATION FORM

DATE OF BIRTH: _____

PHONE: _____

ADDRESS: _____

EMAIL: _____

GENDER IDENTITY: _____

PREFERRED PRONOUNS: _____

RACE/ETHNICITY: _____

EMERGENCT CONTACT NAME, NUMBER & RELATIONSHIP:

DO YOU HAVE, OR HAVE ACCESS TO YOUR:

ID/Driver's License ☐ Birth Certificate ☐ Social Security Card ☐ Social Security ID: _____

Do you have prior experience in Foster Care? YES / NO

Do you have health insurance? ☐ YES, I am enrolled in Medicaid Medicaid ID: _____

☐ YES, I am enrolled in a private plan Plan name: _____

☐ DON'T KNOW / I do NOT have health insurance

Do you receive Food Stamps or other cash aid? YES / NO / DON'T KNOW

Have you ever been a victim of crime? YES / NO

If yes, circle all that apply: Child Physical Abuse and Neglect / Child Sexual Abuse and Assault / Domestic or Family Violence / Physical Assault / Sexual Assault / Arson / Bullying / Burglary / Hate Crime / Human Trafficking / Identity Theft or Fraud / Kidnapping / Mass Violence / Survivor of Homicide Victims / Teen Dating Victimization / Terrorism

HOUSING STATUS: I currently live,

With Parents/Family ☐ With Roommates/Friends/Significant other ☐ On my own ☐ Couch Surfing/Homeless ☐

Other: _____ Is this situation: Permanent (stable) ☐ Non-Permanent (temporary) ☐

Are you seeking help with housing? YES / NO

MENTAL HEALTH:

Are you currently seeing a mental health provider? YES / NO

EMPLOYMENT STATUS:

Are you currently employed? YES / NO If yes, where? _____

Are you seeking help with employment? YES / NO

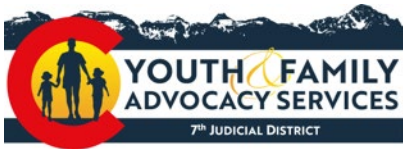
EDUCATION STATUS:

Are you currently enrolled in school? YES / NO If yes, where? _____

Did you graduate from High School or get your GED? YES / NO

Are you interested in attending vocational school, 4-year College, or any other educational program? YES / NO

Are you seeking help with education? YES / NO



NAME: _____

GENERAL HEALTH:

Do you have any food allergies? YES / NO

Do you have a Primary Care Provider? YES / NO If yes, date of last visit (mm/yy): _____

If applicable, are you on birth control? YES / NO Is there a chance you could be pregnant? YES / NO / I Don't Know

Would you like help accessing birth control? YES / NO

What brings you in today?

What are your top 3 stressors?

1. _____
2. _____
3. _____

What do you do to for fun?

How would you rate your overall mental health? Very Good / Good / Fair / Poor / Very Poor

How would you rate your overall physical health? Very Good / Good / Fair / Poor / Very Poor

How satisfied are you with your overall quality of life? Very Satisfied / Satisfied / Unsatisfied / Very Unsatisfied

Client Signature

Date

Case Manager Initials

This form was completed by: client / parent or guardian / case manager or other support worker

If not client, name/contact information: _____