NAME: _____

YOUTH INFORMATION FORM

DATE OF BIRTH: _____ **PHONE:** _____

ADDRESS: _____

EMAIL: _____ **GENDER IDENTITY:** _____

PREFFERED 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*

YOUTH & FAMILY ADVOCACY SERVICES
7th Judicial District

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: _____