YOUTH NEEDS ASSESSMENT

This assessment is to help you be successful by determining your needs

so we can connect you with resources to thrive!

Date: _____

Participant Contact Information

Name: _____ Date of birth (month/day/year): _____
(First and Last name)

Sex at Birth (Check one): ☐ Female ☐ Male

School/Program site: _____

Home Address: _____

City: _____ Zip Code:_____

Your Cell Phone: _____ Email Address: _____

Are you enrolled in special education? ☐ Yes ☐ No ☐ I don't know

Guardian and Household Information

Are you on probation/ in the juvenile system?

☐ Yes ☐ No

Are you currently in foster care?

☐ Yes ☐ No

Are either of your parents currently in prison, or have they been?

☐ Yes ☐ No ☐ I don't know

Do you/your family receive public assistance (i.e. EBT, Medi-Cal, etc.)?

☐ Yes ☐ No ☐ I don't know

Are you currently employed?

☐ Full-time ☐ Part-time ☐ Not Employed

If you are not employed, are you looking for a job?

☐ Yes ☐ No

Who is/are your parent(s) or guardian(s) you live with the majority of the time?

_____

Are your biological parents…? (Select all that apply):

☐ Living together ☐ Married ☐ Separated ☐ Single ☐ Remarried ☐ Living with another partner

☐ One or more widowed (passed away) ☐ I don't know ☐ Other

I would like more information about (circle all that apply):

1. Public assistance for housing
2. Public assistance for food
3. Low-cost/free clothing
4. Bullying info and support
5. Reporting abuse
6. Drug and alcohol prevention
7. Learning how to manage money
8. Getting a mentor
9. Career planning
10. Serving the community
11. Being in a youth leadership group
12. Help succeeding in school/tutoring
13. Life skills (Example: being more organized & prepared for adulthood)

If you could improve anything in your life right now, what would it be?

_____

_____

_____

_____

Is there anything else you would like to share or say more about?

_____

_____

_____

_____

Updated April 2022

The following is a screener to help identify whether you are experiencing high stress. The goal is to make available to those students an ACEs overcoming program called Mind Matters. If your combined score of questions 1,4,7,10,14 and 15 is a total of 14 or higher, you will have an option to voluntarily participate in the Mind Matters program. **The symptoms described here are what you have experienced in the last 30 days.**

ABBREVIATED PCL-C SELF-REPORT

Name: _____ Date: _____

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle one** of the numbers to the right to indicate how much you have been **bothered** by that problem **in the last 30 days**.		Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated disturbing *memories, thoughts, or images* of a stressful experience from the past	1	2	3	4	5
4	Feeling *very upset* when *something reminded* you of the stressful experience	1	2	3	4	5
7	Avoiding *activities* or *situations* because they remind you of the stressful experience	1	2	3	4	5
10	Feeling *distant* or *cut off* from other people	1	2	3	4	5
14	Feeling *irritable* or having *angry outbursts*	1	2	3	4	5
15	Having *difficulty concentrating*	1	2	3	4	5