Date: _____

Staff/Intern completing intake:

_____

# FAMILY DEMOGRAPHIC FORM

**Parent/Primary Caregiver #1:**

**First & Last Name:** _____ **Date of Birth:** _____

**Address** _____

City _____ State _____ Zip _____

| **Phone #** | Home | Cell | Work | Comment | Can we mention the Center? | Can we leave a message? |
|---|---|---|---|---|---|---|
| 1) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |
| 2) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |
| 3) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |

**Email** _____ Would you like to receive updates about groups & events? Y / N

**Gender** ☐ Male ☐ Female ☐Transgender ☐Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Do you speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Do you have any functional limitations (i.e. mobility, learning, psychological)?** _____

**Relationship status**

☐ Cohabitating ☐ Married ☐ Never Married ☐ Separated / Divorced ☐ Other: _____

**Current Partner's Name** (if applicable) _____

**Who supports you in caring for your children?** (Check all that apply)

☐ Support from current partner ☐ Support from ex-partner ☐ Support from family
☐ Support from non-family ☐ No support ☐ Other: _____

**Housing** (Check all that apply)

☐ Shelter / Transitional Housing ☐ Public Housing/Section 8 ☐ Rent ☐ Own
☐ Housed with Relative/Friends ☐ Street/Vehicle ☐ Other: _____

**Source of Income** (Check all that apply)

☐ CALWORKS ☐ EDD ☐ Public Assistance ☐ SDI ☐ SSI / SSA ☐ Family Member
☐ None ☐ Work Full-time ☐ Work Part-time ☐ Other: _____

**Monthly Family Income** $_____ Number of persons dependent on this income (incl. self): ___

**Do you have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**Please indicate your highest level of formal education**

☐ Some High School ☐ High School Graduate/GED ☐ Some College/Trade School
☐ Junior College Graduate ☐ College/Trade School Graduate ☐ Graduate & Above
☐ Other: _____

**Are you pregnant?** ☐ Yes, Due Date: _____ ☐ No ☐ Not applicable

**Parent/Primary Caregiver #2:**

☐ Parent/Primary Caregiver #2 **will** be accessing Safe & Sound services.
☐ Parent/Primary Caregiver #2 **will not** be accessing Safe & Sound services. If you checked this box, skip to page 3

☐ Not applicable. If you checked this box, skip to page 3

**First & last name:** _____ **Date of Birth:** _____

**Address** _____

City _____ State _____ Zip _____

| **Phone #** | Home | Cell | Work | Comment | Can we the Center? | Can we a |
|---|---|---|---|---|---|---|
| 1) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |
| 2) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |
| 3) _____ | ☐ | ☐ | ☐ | _____ | Y / N | Y / N |

**Email** _____ Would you like to receive updates about groups & events? Y / N

**Gender** ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Do you speak English fluently?** ☐ Yes ☐ No ☐Somewhat

**Do you have any functional limitations (i.e. mobility, learning, psychological)?** _____

**Relationship status**
☐ Cohabitating ☐ Married ☐ Never Married ☐ Separated / Divorced ☐ Other: _____

**Partner's Name** (if applicable) _____

**Who supports you in caring for your children?** (Check all that apply)
☐ Support from current partner ☐ Support from ex-partner ☐ Support from family
☐Support from non-family ☐ No support ☐ Other: _____

**Housing** (Check all that apply)
☐ Shelter / Transitional Housing ☐ Public Housing/Section 8 ☐ Rent ☐ Own
☐ Housed with Relative/Friends ☐ Street/Vehicle ☐ Other:_____

**Source of Income** (Check all that apply)
☐ CALWORKS ☐ EDD ☐ Public Assistance ☐ SDI ☐ SSI / SSA ☐ Family Member
☐ None ☐ Work Full-time ☐ Work Part-time ☐ Other: _____

**Monthly Family Income** $_ _____ Number of persons dependent on this income (incl. self): ___

**Do you have healthcare coverage?**
☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**Please indicate your highest level of formal education**
☐ Some High School ☐ High School Graduate/GED ☐ Some College/Trade School
☐ Junior College Graduate ☐ College/Trade School Graduate ☐ Graduate & Above
☐ Other: _____

**Are you pregnant?** ☐ Yes, Due Date: _____ ☐ No ☐ Not applicable

**Child 1: First & Last Name:** _____ **Date of Birth** _____

**Gender** ☐ Male ☐ Female ☐ Transgender

**Address** ☐ Same as mine ☐ Other _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Does this child speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Please report any functional limitations (i.e. mobility, learning, psychological)** _____

**Please list this child's allergies** _____

**Does this child have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**How is this child related to you?** ☐ Biological child ☐ Adopted child ☐ Relative ☐ Foster Child ☐ Other

**Name of school or preschool** _____ Grade _____

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**Child 2: First & Last Name:** _____ **Date of Birth** _____

**Gender** ☐ Male ☐ Female ☐ Transgender

**Address** ☐ Same as mine ☐ Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Does this child speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Please report any functional limitations (i.e. mobility, learning, psychological)** _____

**Please list this child's allergies** _____

**Does this child have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**How is this child related to you?** ☐ Biological child ☐ Adopted child ☐ Relative ☐ Foster Child ☐ Other

**Name of school or preschool** _____ Grade _____

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**Child 3: First & Last Name:** _____ **Date of Birth** _____

**Gender** ☐ Male ☐ Female ☐ Transgender

**Address** ☐ Same as mine ☐ Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Does this child speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Please report any functional limitations (i.e. mobility, learning, psychological)** _____

**Please list this child's allergies** _____

**Does this child have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**How is this child related to you?** ☐ Biological child ☐ Adopted child ☐ Relative ☐ Foster Child ☐ Other

**Name of school or preschool** _____ Grade _____

**Child 4: First & Last Name:** _____ **Date of Birth** _____

**Gender** ☐ Male ☐ Female ☐ Transgender

**Address** ☐ Same as mine ☐ Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Does this child speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Please report any functional limitations (i.e. mobility, learning, psychological)** _____

**Please list this child's allergies** _____

**Does this child have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**How is this child related to you?** ☐ Biological child ☐ Adopted child ☐ Relative ☐ Foster Child ☐ Other

**Name of school or preschool** _____ Grade _____

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**Child 5: First & Last Name:** _____ **Date of Birth** _____

**Gender** ☐ Male ☐ Female ☐ Transgender

**Address** ☐ Same as mine ☐ Other: _____

**Ethnicity** _____

**Preferred Language** ☐ English ☐ Spanish ☐ Other: _____

**Does this child speak English fluently?** ☐ Yes ☐ No ☐ Somewhat

**Please report any functional limitations (i.e. mobility, learning, psychological)** _____

**Please list this child's allergies** _____

**Does this child have healthcare coverage?**

☐ Healthy San Francisco ☐ Medi-Cal ☐ None ☐ Private: _____ ☐ Other: _____

**How is this child related to you?** ☐ Biological child ☐ Adopted child ☐ Relative ☐ Foster Child ☐ Other

**Name of school or preschool** _____ Grade _____

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*Please request an additional form if you have more than five children.*