

Date:
Staff/Intern completing intake:

FAMILY DEMOGRAPHIC FORM

Parent/Primary Caregiver #1:						
First & Last Name:			Date of	Birth:		
Address						
City						
Phone # 1)	Home	Cell	Work	Comment	Y/N	a message? Y / N
2)					Y / N	
3)	П	Ш			Y/N	I / IN
Email	Would	d you lik	ke to recei	ve updates abo	out groups & events?	Y / N
Gender □ Male □ Fema	le	□Trans	gender	□Other:		
Ethnicity						
Preferred Language □ English	□ Spar	nish	□ Othe	r:		
Do you speak English fluently?	□Yes□	No E	⊐ Somewl	nat		
Do you have any functional limitat	ions (i.e	. mobil	ity, learn	ing, psycholo	ogical)?	
Relationship status □ Cohabitating □ Married Current Partner's Name (if applical				=	-	r:
Who supports you in caring for you	-					
□ Support from current parts □ Support from non-family	ner	□ Su		n ex-partner	□ Support from far □ Other:	nily
Housing (Check all that apply) □ Shelter / Transitional Housi □ Housed with Relative/Frie	_			ng/Section 8 cle		
Source of Income (Check all that ap		tance	□ SDI	□ SSI,	∕SSA □ Family Men	ıber
□ None □ Work Full-t	ime		□ Worl	x Part-time	□ Other:	
Monthly Family Income \$		Num	ber of pe	rsons depende	ent on this income (incl. s	self):
Do you have healthcare coverage?						
□ Healthy San Francisco □ M	ledi-Cal	□ N	one	□ Private: _	🗆 Other:	
Please indicate your highest level □ Some High School			ition Graduate	/CED	□ Some College/Tra	da Schaol
☐ Junior College Graduate ☐ Other:	_			Graduate	☐ Graduate & Above	ac scriour
Are you pregnant? □ Yes, Due Date	e:			No [□ Not applicable Page 1, r	evised 4/15/15

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: ___ State ____ Zip Can we Can we Phone # Home Cell Work Comment the Center? Y/N Y/N Y/N Y/N Y/N Y / NWould you like to receive updates about groups & events? Y / N □ Male Gender □ Female ☐ Transgender ☐ Other: Ethnicity **Preferred Language** □ English □ Other: _____ □ Spanish Do you speak English fluently? □ Yes □ No □Somewhat Do you have any functional limitations (i.e. mobility, learning, psychological)? **Relationship status** □ Never Married □ Separated / Divorced □ Other: _____ □ Cohabitating □ Married 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 □ 0wn □ Public Housing/Section 8 □ Rent ☐ Housed with Relative/Friends □ Street/Vehicle □ Other: **Source of Income** (Check all that apply) □ CALWORKS □ EDD □ Public Assistance □ SDI □ SSI / SSA □ Family Member □ Work Full-time □ None □ Work Part-time □ Other: Monthly Family Income \$_ ____ Number of persons dependent on this income (incl. self): ____ Do you have healthcare coverage? □ Private: _____ □ Other: ____ ☐ Healthy San Francisco ☐ Medi-Cal □ None 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:

□ No

□ Not applicable

Are you pregnant? □ Yes, Due Date:

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	
	ogigal)
Please report any functional limitations (i.e. mobility, learning, psycholological limitations) 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 □ Re	
Name of school or preschool	Grade
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 properties of the pro	ogical)
Please list this child's allergies	
Does this child have healthcare coverage?	
□ Healthy San Francisco □ Medi-Cal □ None □ Private:	
How is this child related to you? □ Biological child □ Adopted child □ Re	
Name of school or preschool	Grade
Child 3: First & Last Name:	Date of Birth
Gender □ Male □ Female □ Transgender	
Address D Come as mine D Others	
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 properties of the pro	ngical)
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 □ Re	lative □ 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, psych	ological)
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? \Box Biological child \Box Adopted child \Box	Relative □ Foster Child □ Other
Name of school or preschool	
Child 5: First & Last Name:	Date of Birth
Child 5: First & Last Name:	Date of Birth
Gender □ Male □ Female □ Transgender	
Gender □ Male □ Female □ Transgender Address □ Same as mine □ Other:	
Gender □ Male □ Female □ Transgender Address □ Same as mine □ Other: Ethnicity	
Gender □ Male □ Female □ Transgender Address □ Same as mine □ Other: Ethnicity Preferred Language □ English □ Spanish □ Other:	
Gender □ Male □ Female □ Transgender Address □ Same as mine □ Other:	ological)
Gender □ Male □ Female □ Transgender Address □ Same as mine □ Other:	ological)
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, psych Please list this child's allergies □ Does this child have healthcare coverage?	ological) □ Other: Relative □ Foster Child □ Other

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