Logo, company name

Description automatically generatedBirth & Beyond Family Resource Centers **Family Information Form: Child Information**

How many total children?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s Date (Month/Day/Year): | |  |  | | --- | --- | | **COMPLETED BY STAFF:** | | | Staff ID: |  | | Client ID: |  | | Funding Source: |  | |
| **Child’s First Name:** |  |
| **Child’s Middle Name:** |  |
| **Child’s Last Name:** |  |
| **Date of Birth** (Month/Day/Year)**:** |  |
| **Gender:** | M Male F Female X Non-Binary NL Not Listed  Prefer not to answerLogo  Description automatically generated | |
| **Race/Ethnicity:** | 2 Asian 3 Black/African American 4 Latino/Hispanic 5 Pacific Islander  6 White 7 Hmong 8 Russian Ukrainian 9 Multiracial 10 Other | |
| **Primary Language:** | 8 [*name of translated language]* 1 English 8 Other: | |
| **Relationship to You:** | 3 Son 4 Daughter 6 Grandchild 8 Foster child 11 Other | |
| **Healthcare/Medical Insurance:** | M Medi-Cal O Other N None U Unknown | |

|  |  |  |  |
| --- | --- | --- | --- |
| **COMPLETE FOR EACH CHILD 0-5 YEARS OLD** | **YES**1 | **NO**2 | **DON’T KNOW**3 |
| 8. Has your child seen a dentist in the last six months? |  |  |  |
| 9. Do you need assistance in accessing dental care for your child? |  |  |  |
| 10. Has your child been seen by the doctor for a routine checkup in the past 12 months? |  |  |  |
| 11. Do you need assistance accessing medical care for your child? |  |  |  |
| 12. Do you have any concerns about your child’s development? (ex: Developmental delay, speech/language difficulties, physical/mental issues, emotional/behavioral issues) |  |  |  |
| 12a. If Yes, have you consulted a doctor or specialist about your concern |  |  |  |
| 12b. Do you need assistance in accessing a doctor or specialist for your concern? |  |  |  |
| 13. In the past year, has your child received a vision screening? |  |  |  |
| a hearing screening? |  |  |  |
| a developmental/ASQ screening? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please tell us the extent to which the following statements are true of your child:** | **NOT**  **TRUE**1 | **SOMEWHAT TRUE**2 | **VERY**  **TRUE**3 |
| Your child stays calm and in control when faced with a challenge |  |  |  |
| Your child calms themself when upset |  |  |  |
| Your child adjusts well to changes in routine |  |  |  |
| Your child has opportunities for fun at least once every day |  |  |  |
| Your child has at least two non-parent adults who take a genuine interest in them(ex: auntie, teacher) |  |  |  |
| If your child is old enough to talk, they openly share their feelings with you |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **In the past 7 days, how many days did you or someone in your family engage in the following activities with your child:** | **0**  days | **1** | **2** | **3** | **4** | **5** | **6** | **7**  days |
| Read with your child for more than 10 minutes |  |  |  |  |  |  |  |  |
| Talked with your child about things that happened during the day |  |  |  |  |  |  |  |  |
| Told stories or sang songs together |  |  |  |  |  |  |  |  |
| Played one-on-one with your child (ex: exercise, played sports, colored, built Legos) |  |  |  |  |  |  |  |  |
| Used the same bedtime routine (ex: read books, bath, brush teeth) |  |  |  |  |  |  |  |  |
| Sat and shared a meal together |  |  |  |  |  |  |  |  |

**\*\*PAT HOME VISITATION ONLY\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| Participation in other programs  *(Select ALL that apply)* | **Program** | **Start Date** | **End Date** |
| Early Head Start |  |  |
| Head Start |  |  |
| Family Literacy Program |  |  |
| Childcare/Early Childhood Program  Center-Based or Home-Based?  Licensed or Accredited? |  |  |
| Kindergarten |  |  |
| Early Intervention Services |  |  |
| Other *(specify)*: |  |  |