



### Client Information

|  |  |   |           |
|--|--|---|-----------|
| First Name   |  | Middle Name   | Last Name |
| Date of Birth ____/____/____<br>MM DD YYYY   |  | Gender <input type="checkbox"/> M <input type="checkbox"/> F  |           |
| <b>Client Type</b><br><input type="checkbox"/> Child less than 3 years old<br><input type="checkbox"/> Child from 3 - 5 years<br><input type="checkbox"/> Parent/Guardian/Caregiver<br><input type="checkbox"/> Other Family Member<br><input type="checkbox"/> Provider   |  | <b>Relationship</b><br><input type="checkbox"/> Mother<br><input type="checkbox"/> Father<br><input type="checkbox"/> Daughter<br><input type="checkbox"/> Son<br><input type="checkbox"/> Primary Client<br><input type="checkbox"/> Grandparent<br><input type="checkbox"/> Grandchild<br><input type="checkbox"/> Foster Parent<br><input type="checkbox"/> Foster or other non-related child<br><input type="checkbox"/> Legal Guardian<br><input type="checkbox"/> Provider/caregiver<br><input type="checkbox"/> Other relative<br><input type="checkbox"/> Don't Know/Decline  |           |
| <b>What is your ethnicity</b> (check only one)<br><input type="checkbox"/> Alaskan Native/American Indian<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black/African-American<br><input type="checkbox"/> Hispanic/Latino<br><input type="checkbox"/> Vietnamese<br><input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White<br><input type="checkbox"/> Multiracial<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> Decline to answer |  | <b>What is your primary language spoken at home?</b><br>(check only one)<br><input type="checkbox"/> English<br><input type="checkbox"/> Spanish<br><input type="checkbox"/> Mixteco<br><input type="checkbox"/> Hmong<br><input type="checkbox"/> Vietnamese<br><input type="checkbox"/> Korean<br><input type="checkbox"/> Mandarin (Putonghua)<br><input type="checkbox"/> Farsi (Persian)<br><input type="checkbox"/> Filipino(Tagalog)<br><input type="checkbox"/> Somali<br><input type="checkbox"/> Arabic<br><input type="checkbox"/> Cambodian<br><input type="checkbox"/> Chinese<br><input type="checkbox"/> Other<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> Decline to answer |           |
| Home Phone   |  | Email   |           |
| Work Phone   |  | Cell Phone  |           |
| Address, Apt.  |  |   |           |
| City   |  | State   | Zip       |

**FOR OFFICE USE ONLY:**

|   |              |  |             |                                   |
|---|--------------|--|-------------|-----------------------------------|
| Program Start Date ____/____/____<br>MM DD YYYY |              | Consent Form Signed ____/____/____<br>MM DD YYYY |             | <input type="checkbox"/> Declined |
| Service Site                                    | Case Manager |  | Referred by |                                   |