Triple P Provider Name: ____________________________________ **Provider Agency:** ____________________________________

Triple P Mecklenburg

FAMILY INFORMATION & CAREGIVER CONTACT FORM

Caregiver (First Name, Last Initial): ________________________ **Caregiver's Year of Birth** _________ **Zip Code:**________

Caregiver's SEX: ☐ Male ☐ Female **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Triple P Service: ☐Level 3/Primary Care **0-12** ☐Level 3/Primary Care **TEEN** ☐Level 3/Stepping Stones ☐Level 4/Standard

Relationship to child ___________________ **Number of Children in the home:** ____ **Number of adults in the home:** ___

Child's Presenting Problem:____

Does the child experience any of the following? (CHECK all that apply) ☐A vision or hearing impairment
☐A physical disability ☐A developmental delay ☐A restrictive/therapeutic diet prescribed by a health provider
☐An intellectual/mental disability ☐A severe chronic illness that results in regular hospitalizations

Pre-test Measures Completed? ☐**Yes** (Date_____________) ☐**No** (☐BRIEF TRIPLE P ☐ other__________________________)

DATE	CAREGIVER(S) RELATIONSHIP	BRIEF DESCRIPTION OF ACTIVITIES	TIME SPENT

Post-Measures Completed: ☐Yes (Date_____________) ☐Not Applicable ☐No (Check reason below)
☐Still providing services ☐Didn't show for last session ☐Decided not to return ☐Measures not given
☐Lost contact with family ☐Other: ____

Return to: Triple P Mecklenburg – c/o Cathy Henderson, Southeast Health Department, 249 Billingsley Road, Charlotte, NC 28211

Updated 2-1-16