

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: _____