Date Referred:	Case #:	Referred by:

CHILD INFORMATION

Child's Full Name:	DOB: Age:	Gender: ☐ M ☐ F	Race:
Physical Address:		Phone#: ( )	
City:	State:	ZIP Code:	

FAMILY INFORMATION

Mother's Name:	Mother's Phone: ( )	
Address: (If different from child)	Employer:	Employer phone no.: ( )

Father's Name:	Father's Phone: ( )	
Address: (If different from child)	Employer:	Employer phone no.: ( )

Lives With (If not with parents): Relationship:	School: Grade:	School Status: (Preschool, Enrolled, Dropped out, Suspended, etc)

Indicate reason for Case Management Services and any requirements of the parents:

Identify the goals for the child (Ex.).

Identify the goals for the parent (Ex.).

Has this family received previous parenting services? Yes ☐ No ☐
If so, what for? Please include name of Provider below:

PRIMARY CARE (0-12) PROBLEM CHECKLIST (INFANTS, TODDLERS, PRESCHOOL, ELEMENTARY)

*** BEHAVIORS ARE LISTED ACCORDING TO TYPICAL DEVELOPMENTAL STAGE BUT MAY BE USED UNIVERSALLY. PLEASE CHECK ALL THAT APPLY:**

☐ Promoting Development (Infants)
☐ Crying (Infants)
☐Sleep Patterns (Infants)
☐ Separation Anxiety (Infants)
☐ Whining (Toddlers)
☐Tantrums (Toddler)
☐Toilet Training (Toddler)
☐ Hurting Others (Toddler)
☐ Disobedience I (Toddler)
☐Sharing (Toddler)
☐Language (Toddler)
☐Bedtime Problems (Toddler)

☐ Disobedience II (Preschool)
☐ Fighting and Aggression (Preschool)
☐Separation Problems (Preschool)
☐Interrupting (Preschool)
☐ Having Visitors (Preschool)
☐ Going Shopping (Preschool)
☐Cleaning Up (Preschool)
☐ Nightmares (Preschool)
☐ Mealtimes Problems (Preschool)
☐Traveling in the Car (Preschool)

☐ Self- Esteem (Elementary School)
☐Behavior at School (Elementary School)
☐ Homework (Elementary School)
☐Being Bullied (Elementary School)
☐Stealing (Elementary School)
☐ Lying (Elementary School)
☐ Fears (Elementary School)
☐Bedwetting (Elementary School)
☐ ADD/ADHD (Elementary School)
☐Sports (Elementary School)
☐ Creativity (Elementary School)

☐ OTHER: (PLEASE EXPLAIN)

TRIPLE P TEEN (13-16) PROBLEM CHECKLIST (ADOLESCENTS, TEEN, EARLY ADULTHOOD)

☐Smoking	☐Eating Habits	☐Taking Drugs
☐Truancy	☐Rudeness and Disrespect	☐Friends and Peer Relationships
☐Sexual Behavior and Dating	☐Coping with Anxiety	☐Money and Work
☐Fads and Fashion	☐Coping with Depression	☐ DJJ/Legal Involvement

Please use this space to elaborate on any items checked in the problem checklist and provide any other information that may be helpful. (Example: recent change in family dynamics, death, divorce, etc.)

Please indicate how long these problems have existed.

Referral Person Name:	Ext.

Supervisor Name:	Ext.