

PARENT QUESTIONNAIRE

(Please print or type. Please be sure to include the zip codes for all addresses.)

Your Name: _____

Age: _____ **Date of Birth :** _____

Your Children's Names:

<u>Name</u>	<u>Date of Birth</u>	<u>Place of Birth</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names of Persons Living in Your Household Other Than You or Your Children:

<u>Name</u>	<u>Relationship</u>
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What are the current parenting time arrangements for the child(ren)?

Marital History:

Date of Marriage: _____ **Date of Separation:** _____

Who made the decision to separate? _____

Was there ever any physical abuse during the marriage? ___ Yes ___ No

If so, were any incidents of abuse reported to the police? ___ Yes ___ No

(Please provide copies of police reports, if available.)

Did alcohol or drug use contribute to problems in your marriage? ___ Yes ___ No

If you have remarried, please give your spouse's name, birthdate, and the date of your marriage:

If you are currently in a significant relationship with someone who is a prospective step-parent, please give his or her name, birthdate, address, and phone number:

If you have been married previously, please provide the following information:

Name of Former Spouse: _____

Date of Marriage: _____ **Date of Divorce:** _____

Names and birthdates of any children born during this marriage:

Legal Situation:

In which county is this current action filed? _____

What is the Docket Number? _____

Date of Temporary Orders: _____

(Please provide a copy of the court order if one has been issued.)

If this is a modification, what was the date of the initial decree? _____

(Please provide a copy of the Permanent Orders.)

Name, address (including zip code), and phone number of your attorney:

Name, address (including zip code), and phone number of the Children's Legal Representative (if applicable):

Information About Your Family:

Father's Name: _____ **Age:** _____

Mother's Name: _____ **Age:** _____

Siblings:

<u>Name</u>	<u>Age</u>	<u>Residence (City and State)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If your parents were divorced, give date: _____

If remarried, give date: _____

Employment Information

Occupation:

Employer: _____

Work hours: **From:** _____ **To:** _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Does your work require any out-of-town travel? If so, please provide details:

How much vacation time do you get each year? _____

Medical / Mental Health Information:

Name, address, and phone number of your primary care physician:

Do you have any chronic or recurrent health problems or physical handicaps?

Yes No **If yes, please give details:**

Have you ever been in psychotherapy or counseling? Yes No **If yes, please provide the following information for each therapist that you've seen during the past five years:**

Name of Therapist: _____

Dates of Treatment: From: _____ **To:** _____

Address:

Phone #: _____

(If you have had more than one therapist in the past five years, please provide the same information regarding each therapist.)

Have you ever been hospitalized psychiatrically? Yes No

If yes, give dates, names and addresses of hospital(s):

Have you ever received treatment for an alcohol or drug abuse problem?

Yes No **If yes, provide dates, name of program or person seen, address, and phone numbers:**

Religious Affiliation:

Do you have a religious affiliation? If so, give name of religion: _____

Do you belong to a church, mosque, or synagogue? ____ Yes ____ No

If yes, how often in the past year did you attend services? _____

Do your children attend services? ____ Yes ____ No

If so, how often? _____

Information about Your Children:

Please provide the following information regarding each of your children.

Name of Child: _____ D.O.B. _____

School: _____ Grade: _____

Principal: _____ Teacher: _____

School Address:

School phone number: _____

If your child attends a day care center, complete the following:

Name of Day Care Center: _____

Director: _____ Teacher: _____

Address:

Phone Number: _____

Does your child have any significant problems in school or receive special education services? If so, please describe:

Does your child have any significant medical problems? If so, please describe:

Name, address, and phone number of your child's pediatrician:

Has your child ever been in psychotherapy or counseling? If so, please provide the following information:

Name of Therapist: _____

Dates of Treatment: From: _____ **To:** _____

Address:

Phone #: _____

Please provide a list of all of the professionals with whom I should speak and/or from whom I should obtain records. Be sure to include the professional's name and degree, mailing address, phone number, and fax number (if you have it). Examples of the types of professionals with whom I might want to gather information regarding parents and children include psychotherapists, physicians (including pediatricians), school teachers, speech therapists, drug and alcohol counselors, marital therapists, and educational specialists.

Please provide a written parenting plan proposal based on what you believe to be the best interest of your child(ren). To help with this, I have placed an outline on this website.

Please provide a copy of your child(ren)'s schedule including but not limited to school time, activities, camps, and psychotherapy appointments.