

# CROOK HUIDBURG LAW, PLLC

400 N Walker Ave, Oklahoma City, Oklahoma, 73102 | (405) 666-5668

[Casey@crookhudiburglaw.com](mailto:Casey@crookhudiburglaw.com) | [info@crookhudiburglaw.com](mailto:info@crookhudiburglaw.com) | [James@crookhudiburglaw.com](mailto:James@crookhudiburglaw.com)

Please answer the following questions to the best of your ability. Your answers will save valuable time and aid us in representing you better. All the answers are under the strictest confidentiality.

Today's Date: \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Does an attorney currently represent you?  Yes  No If "yes" name/firm: \_\_\_\_\_

## **Your Information:**

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Other Names Used (maiden, aliases, etc.): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred Mailing Address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Current Spouse: \_\_\_\_\_

Are you of Native American Descent?  Yes  No

Social Media Account Names: Facebook: \_\_\_\_\_ Instagram: \_\_\_\_\_

TikTok: \_\_\_\_\_ Twitter: \_\_\_\_\_ YouTube: \_\_\_\_\_

## **Current Spouse/ Significant Other:**

Do you reside with your Current Spouse?  Yes  No If "yes" for how long? \_\_\_\_\_

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Media Account Names: Facebook: \_\_\_\_\_ Instagram: \_\_\_\_\_

TikTok: \_\_\_\_\_ Twitter: \_\_\_\_\_ YouTube: \_\_\_\_\_

Do you have a Criminal Case History?  Yes  No (If yes, please complete Page No. 7)

## **Opposing Party Information:**

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Primary form of Communication (email, text, phone etc.): \_\_\_\_\_

## **Employment/ Education Information:**

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Length of Employment: \_\_\_\_\_ Hours Works per Week: \_\_\_\_\_

Highest Level of Education or Training: \_\_\_\_\_ Are you currently in School?  Yes  No

If "yes", list where, what you are studying, and days/hours attending: \_\_\_\_\_

Military Service, if any: \_\_\_\_\_

**INFORMATION ABOUT CHILD(REN):**

**Child One:**

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_ City: \_\_\_\_\_

**Is this Child of Native American Descent?  Yes  No**

**Does this Child Reside with You?  Yes  No**

If "No," List Residence: \_\_\_\_\_

**Has this Child Resided at Your Address for Five (5) Years or More?  Yes  No**

If "No," List ALL Places (s)he has lived:

**Is this Child currently enrolled in School?  Yes  No if "yes":**

Name of Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Is your child on an IEP at school? If yes, Describe when and why: \_\_\_\_\_

**Does your Child attend Daycare or receive Childcare?  Yes  No if "yes":**

Name of Daycare or Childcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**List all Medical Providers (including Primary Care Physicians):**

Date of Last Visit:	Provider	Contact Information	Why does your Child see this Physician:

**Has this Child ever seen a Counselor, Psychologist or Psychiatrist?  Yes  No if "yes":**

Dates Attended	Counselor Name	Contact Information	Reason for Counseling

**Is this child currently on any Medication?  Yes  No if "yes" please list the name and Prescribing Physician: \_\_\_\_\_**

**List Extracurricular Activities for your child, including dates and times the activity occurs:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please continue to the next page. →  
If you have no more children please skip to page 5**

**Child Two:**

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_ City: \_\_\_\_\_

**Is this Child of Native American Descent?  Yes  No**

**Does this Child Reside with You?  Yes  No**

If "No," List Residence: \_\_\_\_\_

**Has this Child Resided at Your Address for Five (5) Years or More?  Yes  No**

If "No," List ALL Places (s)he has lived:

**Is this Child currently enrolled in School?  Yes  No if "yes":**

Name of Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Is your child on an IEP at school? If yes, Describe when and why: \_\_\_\_\_

**Does your Child attend Daycare or receive Childcare?  Yes  No if "yes":**

Name of Daycare or Childcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**List all Medical Providers (including Primary Care Physicians):**

Date of Last Visit:	Provider	Contact Information	Why does your Child see this Physician:

**Has this Child ever seen a Counselor, Psychologist or Psychiatrist?  Yes  No if "yes":**

Dates Attended	Counselor Name	Contact Information	Reason for Counseling

**Is this child currently on any Medication?  Yes  No if "yes" please list the name and Prescribing Physician: \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_

**List Extracurricular Activities for your child, including dates and times the activity occurs:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page. →  
If you have no more children please skip to page 5**

**Child Three:**

Name First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ DOB: \_\_\_\_\_ City: \_\_\_\_\_

**Is this Child of Native American Descent?  Yes  No**

**Does this Child Reside with You?  Yes  No**

If "No," List Residence: \_\_\_\_\_

**Has this Child Resided at Your Address for Five (5) Years or More?  Yes  No**

If "No," List ALL Places (s)he has lived:

**Is this Child currently enrolled in School?  Yes  No if "yes":**

Name of Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Is your child on an IEP at school? If yes, Describe when and why: \_\_\_\_\_

**Does your Child attend Daycare or receive Childcare?  Yes  No if "yes":**

Name of Daycare or Childcare Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**List all Medical Providers (including Primary Care Physicians):**

Date of Last Visit:	Provider	Contact Information	Why does your Child see this Physician:

**Has this Child ever seen a Counselor, Psychologist or Psychiatrist?  Yes  No if "yes":**

Dates Attended	Counselor Name	Contact Information	Reason for Counseling

**Is this child currently on any Medication?  Yes  No if "yes" please list the name and Prescribing Physician: \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_

**List Extracurricular Activities for your child, including dates and times the activity occurs:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page. →  
If you have no more children please skip to page 5**

**Medical Providers (Parent/ Your Information):**

Provider:	Contact Information:	Reason for Provider:	Date of Last Visit:

**Are you currently on any Medication?  Yes  No**

if “yes” please list the Name, Prescribing Physician, and Length of time taking Medication :

---



---



---

**Do you have any significant health concerns?  Yes  No**

If “yes” please describe:

---



---

**Drugs/ Alcohol:**

**Do you have a History of Drug or Alcohol Abuse?  Yes  No**

Date of Last Drug/ Alcohol Screen: \_\_\_\_\_ Provider: \_\_\_\_\_

**Have you Attended a Rehab Facility?  Yes  No** if “yes”

Name of Facility: \_\_\_\_\_ Dates Attended: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Criminal History:**

Please include all Charges including dropped charged, deferred sentences and parole information for each arrest:

Date of Arrest	Case Number	Location	City/State/ County	Charges & Final Results

**Has your Driver’s License been modified or restricted for any reason?  Yes  No** If “yes”, explain:

---

Please continue to the next page. →

**History of Violence:**

**Are you a Victim of Domestic Violence or have you ever been the Perpetrator in a Domestic Violence Incident?**  Yes  No if “yes” please provide a detailed description:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Was a Police Report filed?**  Yes  No if “yes”: (please document if more than one incident has occurred)

Date Filed: \_\_\_\_\_ Location of Incident: \_\_\_\_\_

Victim: \_\_\_\_\_ Aggressor: \_\_\_\_\_

Date Filed: \_\_\_\_\_ Location of Incident: \_\_\_\_\_

Victim: \_\_\_\_\_ Aggressor: \_\_\_\_\_

**Was a VPO Filed?**  Yes  No if “yes”:

Date Filed: \_\_\_\_\_ Case Number: \_\_\_\_\_

Name of Plaintiff: \_\_\_\_\_ Defendant: \_\_\_\_\_

County Filed: \_\_\_\_\_ Judge: \_\_\_\_\_

**DHS/CPS Contact:**

State/County \_\_\_\_\_ Case Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Incident: \_\_\_\_\_

Adults Involves: \_\_\_\_\_

Children Involved: \_\_\_\_\_

Allegations: \_\_\_\_\_

If child(ren) were removed from your home, Date Removed: \_\_\_\_\_ Date Returned: \_\_\_\_\_

**Household Residents:**

**How many people reside at your residence (including yourself)?** Adults: \_\_\_\_\_ Children: \_\_\_\_\_

Provide the following information for any resident not yet mentioned on page 1 – 4:

Full Name	Age	Contact Information	Relationship

**Marriage History:**

**Do you have any prior Marriages, Divorces, or Children not related to this case?**  Yes  No

If “yes”, please provide full names and relation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page. →  
If you don’t have a spouse, please skip to page 8**

**INFORMATION ABOUT SPOUSE:**

**Medical:**

**Are you currently on any Medication?  Yes  No**

if "yes" please list the Name, Prescribing Physician, and Length of time taking Medication :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Drugs/ Alcohol:**

**Do you have a History of Drug or Alcohol Abuse?  Yes  No**

Date of Last Drug/ Alcohol Screen: \_\_\_\_\_ Provider: \_\_\_\_\_

**Have you Attended a Rehab Facility?  Yes  No** if "yes"

Name of Facility: \_\_\_\_\_ Dates Attended: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Criminal History:**

Please include all Charges including dropped charged, deferred sentences and parole information for each arrest:

Date of Arrest	Case Number	Location	City/State/ County	Charges & Final Results

**Has your Driver's License been modified or restricted for any reason?  Yes  No** If "yes", explain:

\_\_\_\_\_

**History of Violence:**

**Are you a Victim of Domestic Violence or have you ever been the Perpetrator in a Domestic Violence Incident?  Yes  No** if "yes" please provide a detailed description:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Was a VPO Filed?  Yes  No** if "yes":

Date Filed: \_\_\_\_\_ Case Number: \_\_\_\_\_

Name of Plaintiff: \_\_\_\_\_ Defendant: \_\_\_\_\_

County Filed: \_\_\_\_\_ Judge: \_\_\_\_\_

**DHS/CPS Contact:**

**Are you involved in any DHS or CPS matters?  Yes  No** if "yes":

State/County \_\_\_\_\_ Case Worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Dates of Incident: \_\_\_\_\_

Adults Involves: \_\_\_\_\_

Children Involved: \_\_\_\_\_

Allegations: \_\_\_\_\_

If child(ren) were removed from your home, Date Removed: \_\_\_\_\_ Date Returned: \_\_\_\_\_

