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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: _____

Witnesses:

Please list any witness you would like the Guardian Ad Litem to contact in this matter:

Name:	Contact Information:	Relationship

Billing Information:

Email Address: _____

Your monthly statement will be emailed to this address. If you do not have an email address, check the box below and we will send it to your preferred mailing address. If you would like the bill to be sent to a different physical or email address, please list it below.

☐ I do not have an email address. (*Invoices will be sent to your preferred mailing address*.)

☐ I would like a paper invoice at this address: _____

City:_____ State:_____ Zip Code:_____

Emergency Contact:

Name First: _____ Middle:_____ Last: _____

Relation: _____ Phone Number: _____

Notes:

_____

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