

Please print a copy.
Complete and return
to our office.



Custody | Parenting Time Questionnaire

OUR CLIENT

Full Legal Name: _____ SSN# _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Place of Birth (country or state): _____

Please mark preferred phone number below.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Email: _____

Current Employer: _____ Current Position: _____

Employer Address: _____ Employer Phone: _____

INCOME INFORMATION

Income: \$ _____ Monthly Gross Wages: \$ _____

Employment Benefits (e.g. phone, vehicle, etc.): _____

Withholding: Single Married # of Dependents Claimed: _____

Federal Withholding: \$ _____ State Withholding: \$ _____ FICA: \$ _____

Health Insurance: \$ _____ Life Insurance: \$ _____

Other Deductions: \$ _____

Net Monthly Take-Home Amount: \$ _____ Paid: Weekly Bi-Weekly Monthly Semi-Monthly

Other Income (e.g. second job): _____

Regular Work Schedule: _____

Please attach copies of: Last three (3) pay stubs

Last W-2/1099

Last Tax Return

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OPPOSING PARTY

Full Legal Name: _____ SSN# _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Place of Birth (country or state): _____

Please mark preferred phone number below.

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Email: _____

Current Employer: _____ Current Position: _____

Employer Address: _____ Employer Phone: _____

Attorney's Name: _____

INCOME INFORMATION

Income: \$ _____ Monthly Gross Wages: \$ _____

Employment Benefits (e.g. phone, vehicle, etc.): _____

Withholding: Single Married

of Dependents Claimed: _____

Federal Withholding: \$ _____

State Withholding: \$ _____ FICA: \$ _____

Health Insurance: \$ _____

Life Insurance: \$ _____

Other Deductions: \$ _____

Net Monthly Take-Home Amount: \$ _____ Paid: Weekly Bi-Weekly Monthly Semi-Monthly

Other Income (e.g. second job): _____

Regular Work Schedule: _____

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CHILDREN

Number of children: _____

Child's Name	Date of Birth (MM/DD/YYYY)	Social Security Number	Age	Still Living at Home	Are they of Native American Heritage?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Present address of children of this marriage:

Address: _____ City: _____ State: _____ Zip: _____

Name(s) & address(es) of person(s) with whom children have lived for the past six (6) months:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

City(ies) and State(s) where children have lived for the past five years:

Address: _____ City: _____ State: _____ Zip: _____

Has there be litigation concerning custody of the children? Yes No

Where (City and State): _____ Case No. _____

Caption of Case: _____ Status: _____

Is there anyone else (other than other parent) who has or claims to have a right to physical custody of or visitation rights with the children?

Yes No If yes, please provide their name(s): _____

Names and Dates of Birth or minor children NOT born to this marriage:

Child's Name	Date of Birth (MM/DD/YYYY)	Who Does Child Live With?
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's Ex
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's E
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's E
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's E
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's E
		<input type="checkbox"/> Lives with you <input type="checkbox"/> Lives with Ex <input type="checkbox"/> Lives with Spouse's E

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CHILDREN CONTINUED

Pre-existing child support obligations paid:

Case Name: _____ Case Number: _____ County and State: _____

Amount of obligation: \$ _____ per _____ Name of Paying Party: _____

PARENTING TIME

Who is to have primary residency? _____

How will parenting time be set out in the temporary order?

Shared Parenting Time Specific Parenting Time Reasonable Parenting Time

WORK-RELATED CHILD CARE COSTS (provide statement from provider)

Paid by: _____ Amount paid: \$ _____ per _____

Providers Name: _____ Providers Address: _____

Attach a copy of verification of day-care/childcare expense.

HEALTH INSURANCE COVERAGE (provide copy of insurance verification)

Which party pays health insurance: _____

Coverage Type: Medical Dental Vision Drug

Name of Insurance Company: _____

Address of Insurance Company: _____

Name(s) of all individuals covered by policy: _____

How much does the parent pay for family coverage? \$ _____ per _____

How much would it cost the parent for the parent only? \$ _____ per _____

Provide a copy of verification of single and family insurance costs.

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DOMESTIC VIOLENCE/MENTAL HEALTH

Are you in a relationship in which you have been physically hurt or threatened by your spouse? Yes No

Has your spouse ever destroyed things that you care about? Yes No

Has your partner ever threatened or abused your children? Yes No

Do you feel afraid of your spouse? Yes No

Do you have guns in your home? Yes No

Has your spouse ever threatened to use them when he/she was angry? Yes No

Do you believe your spouse/significant other abuses alcohol? Yes No

Does your spouse/significant other believe you abuse alcohol? Yes No

Do you believe you abuse alcohol? Yes No

Do you believe your spouse/significant other abuses prescription or illegal drugs? Yes No

Does your spouse/significant other believe you abuse prescription or illegal drugs? Yes No

Do you believe you abuse prescription or illegal drugs? Yes No

Do you believe your spouse/significant other has/have a mental health problem or issue? Yes No

Does your spouse/significant other believe you have a mental health problem or issue? Yes No

Do you believe you have a mental health problem or issue? Yes No

ADDITIONAL INFORMATION: