Purpose Counseling & Mental Health Services, LLC
"Where The Healing Begins"

**Custody Evaluation Parent Intake Form**

Name: _____Age: _____ Sex: _____

Address: _____

_____

Phone: _____ Cell: _____

E-mail: _____

Date of birth: _____ Marital status: _____

If married, list spouse name and contact information: _____
_____
_____

Occupation: _____ Years of Education/Degree: _____
Employer: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Attorney name: _____

Attorney address: _____

_____
Attorney phone: _____Fax: _____ Email: _____

Judge: _____
Court parish: _____ Suit number: _____

Date of marriage: _____Date of divorce: _____
Describe the current custody arrangement (include visitation schedule): _____
_____
_____
_____

Who is the domiciliary parent? _____

Primary physician: _____Physician phone: _____
Physician address: _____
List any medical conditions: _____

_____
_____
_____

List all current medications: _____

_____
_____

List any counselors that you have seen (include contact information):_____

_____
_____
_____
_____

List all other people living in your home:

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Name: _____ Sex: _____ Age: _____ Relationship: _____

Have you been a party in a custody dispute in the past? Y N If so, give a brief description: _____

_____
_____
_____
_____



List all long-term relationships and marriages below (include children from each).

Name: _____ Date met: _____Date of marriage:_____
Date of Separation _____ Date of Divorce: _____

Children (include current ages):_____

Name: _____ Date met: _____Date of marriage:_____
Date of Separation _____ Date of Divorce: _____

Children (include current ages):_____

Name: _____ Date met: _____Date of marriage:_____
Date of Separation _____ Date of Divorce: _____

Children (include current ages):_____

Name: _____ Date met: _____Date of marriage:_____
Date of Separation _____ Date of Divorce: _____

Children (include current ages):_____

Responsible party/guarantor: _____ Social security #: _____

RELEASE/PAYMENT AUTHORIZATION: I agree to provide payment in full at the time of service to Purpose Counseling & Mental Health Services, LLC 162260 Airline Hwy Ste D Prairieville, LA 70769 . I acknowledge that I received a copy of the HIPAA Privacy Notice.

_____
Signature Date

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For each issue below, place a check under the number to decide how much each issue has distressed, worried or bothered you in the past TWO weeks.

1 –Not at all 2 –Slightly 3 –Moderately 4 –Considerably 5 -Extremely

1 Feeling angry 1 2 3 4 5

Feeling timid or shy 1 2 3 4 5

Feeling depressed 1 2 3 4 5

Being easily embarrassed 1 2 3 4 5

Feeling like a failure 1 2 3 4 5

Feeling on the verge of tears 1 2 3 4 5 7

Being ill at ease with others 1 2 3 4 5

Feeling discouraged 1 2 3 4 5

Not feeling like eating 1 2 3 4 5

Lacking friends 1 2 3 4 5

Feeling shy with the opposite sex 1 2 3 4 5

Blaming, criticizing or condemning others 1 2 3 4 5 13

Difficulty holding conversations 1 2 3 4 5

Feeling hopeless 1 2 3 4 5

Having headaches 1 2 3 4 5

Difficulty sleeping 1 2 3 4 5

Staying by yourself a lot 1 2 3 4 5

Feeling tense and nervous 1 2 3 4 5

Upset stomach 1 2 3 4 5

Sexual problems 1 2 3 4 5

Suicidal thoughts 1 2 3 4 5

Problems with family 1 2 3 4 5

Upset by academic concerns 1 2 3 4 5

Problems with spouse or significant other 1 2 3 4 5

Stress related to work 1 2 3 4 5

Stress related to school 1 2 3 4 5

Being overweight 1 2 3 4 5

Problems with anxiety 1 2 3 4 5

Unhappy with living arrangements 1 2 3 4 5

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The following are common concerns of individuals. Please check all that apply to you.

1. My family has a history of (check all that apply): _ poor communication _ counseling _ abuse _ depression _ hospitalization _ alcoholism _ eating disorders _ drug or gambling addiction

2. I use alcohol: _ less than once per week _ more than once per week _ never

3. I use drugs: _ less than once per week _ more than once per week _ never

4. The following have resulted from my use of alcohol/drugs (check all that apply): _ traffic violation _ black outs _ financial problems _ ruined relationship _ health problems _ work or academic problems

5. ___ I have been in trouble with the legal system.

6. ___ I have had an unwanted sexual experience.

7. I have experienced (check all that apply): _ emotional abuse _ sexual abuse _ physical abuse

8. I've tried to control my weight with (check all that apply): _ vomiting _ laxatives _ not eating _ diet pills _ excessive exercise _ other

9. I have thought or tried to (check all that apply): _ harm myself _harm another person

10. At times, I have acted in a violent manner.

11. I have recently had problems with the following (check all that apply): _sleeping _appetite _ fatigue _concentration _weight loss/gain _mood shifts _headaches _anxiety _ medical problems

12. I have difficulty (check all that apply): _expressing my emotions _ controlling my anger _handling stress _accepting myself _ accepting compliments

13. I have experienced a recent (check all that apply): _death _ relationship that ended _ major move

14. ___ Sometimes I hear unwanted voices in my head.