



STATE OF CALIFORNIA
 MADERA SUPERIOR COURT
 Family Court Services
 200 South G Street
 Madera, CA 93637

**CHILD CUSTODY INVESTIGATION
 INTAKE/QUESTIONNAIRE**

PH #: (559) 416-5560 FCS#: _____
 FAX #: (559) 673-8216 CASE #: _____ NEXT COURT DATE: _____

REFERRAL: Child Custody Investigation \$600.00/Parent Limited Scope Investigation/Expanded Mediation \$200.00/parent

Is your address confidential to the other party? YES NO

SECTION 1: YOUR INFORMATION

NAME (Last, First, Middle Initial)		MAIDEN NAME:	OTHER NAMES YOU ARE KNOWN BY:
DATE OF BIRTH:	PLACE OF BIRTH:	ATTORNEY NAME / TELEPHONE # / FAX #:	
HOME TEL. #:	CELL TEL. #:	E-MAIL ADDRESS:	
STREET ADDRESS:		SOCIAL SECURITY#:	DRIVER'S LICENSE # / STATE:
CITY:	STATE:	ZIP CODE:	HOW LONG AT THIS ADDRESS? YEARS: _____ MONTHS: _____
MAILING ADDRESS IF DIFFERENT THAN HOME ADDRESS: (IMPORTANT YOU INCLUDE TO RECEIVE CORRESPONDENCE)			

SECTION 2: CONCERNS AND PROPOSALS

1. What are the **top three** most important concerns you would like to discuss with Family Court Services?

2. Is there a current court order? Yes No

3. **Whether there is a court order or not**, please answer the following questions regarding how things are now:
 - a. At this time, who makes decisions about the child(ren)'s health, education and welfare? _____
 - b. At this time, who do the children live with? _____
 - c. At this time when do the children spend time with each parent? _____

4. Do you want to change how things are now? Yes No IF YES, please answer the following:
 - a. I want to change who makes decisions about the children's health, education and welfare) to: _____
 - b. I want to change who the child/ren live with to: _____
 - c. I want to change the schedule of when the children spend time with each parent to: _____

5. If you want the current parenting plan to change, how would your proposed changes benefit the children?

SECTION 3: CONTACT WITH THE COURTS AND OTHER STATE AGENCIES

A. CRIMINAL COURT

1. List all **YOUR** arrests in the last 10 years:

Date of Arrest:	Charge(s):	Law Enforcement Agency:	Outcome:

2. Have you ever been court ordered to attend:

Batterer's Intervention Program? Drug Treatment? Anger Management? Counseling?

3. Are you currently on Probation or Parole? Yes No IF YES, please state the name, location and telephone number of your probation/parole officer: _____

4. Does anyone else currently living in your home have criminal arrests or convictions? Yes No
IF YES, please state the dates of the arrests, charges and outcomes for all: _____

5. Has the **OTHER** parent ever been arrested? Yes No
IF YES, please state the dates of the arrests, charges and outcomes for all: _____

6. Does anyone else currently living in the other parent's home have criminal arrests or convictions? Yes No
IF YES, please state the dates of the arrests, charges and dispositions for all: _____

B. CHILD PROTECTIVE SERVICES

1. Has Child Protective Services ever received a referral on you, the other parent or your children? Yes No
IF YES, please answer the following questions:

Date Investigated:	Concerns/Allegations:	Outcome of Investigation:

SECTION 4: INFORMATION ABOUT YOUR CURRENT BOYFRIEND, GIRLFRIEND, OR SPOUSE:

Full name:	Date of birth:	Social Security #:
Other names used:	Driver's license #/State:	Date relationship began:
Home phone number:	Cell phone number:	Occupation:
Present employer:	Employer's phone #:	Days/Hours worked:

SECTION 5: INFORMATION ABOUT ALL PRIOR BOYFRIENDS/GIRLFRIENDS OR SPOUSES

Name:	Date relationship Began:	Date Ended:	DOB:	Social security #:	Last known address:

SECTION 6: EDUCATION AND EMPLOYMENT

A. Education Level: Please list the highest grade or level of schooling you completed:
GED High school graduate College courses taken College graduate Post graduate work

1. Are you currently employed? Yes No

2. IF YES, what is your occupation, employer's name, telephone number and employer's address?

3. How long have you been with your current employer? Years: _____ Months: _____

4. Current workdays and hours (please list what time you start work and what time you end work each day):

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

5. Please list your employment history over the past 5 years:

Dates of employment:	Name of employer:	Telephone #:	Occupation:	Reason for leaving:

6. Who takes care of the child(ren) while you are unavailable? Please provide their names and telephone #'s:

SECTION 7: MENTAL HEALTH HISTORY

1. Have you ever been in counseling or therapy? Yes No

IF YES, please list in chronological order (by year) the therapists, counselors, clergy and/or marital counselors who you gone to:

Date:	Doctor/Therapist name:	Complete mailing address:	Telephone #:

Have you ever been hospitalized for psychiatric treatment? Yes No

IF YES, please list hospitals or clinics attended and the dates of treatment:

Date:	Hospital name:	Complete mailing address:	Telephone #:

2. Have you ever taken psychiatric medication? Yes No (for example, for depression, anxiety, etc.)

IF YES, please list the names of all medications and the name, telephone number and the complete mailing address of the physician who prescribed the medication: _____

3. Has the other parent ever been in counseling/therapy or hospitalized for psychiatric treatment? Yes No

IF YES, please list the therapist, agency or hospital that provided the services and the dates of treatment:

4. Has the other parent ever taken psychiatric medication? Yes No

IF YES, please list the names of all medications and the name, telephone number and the complete mailing address of the physician who prescribed the medication: _____

SECTION 8: ALCOHOL AND SUBSTANCE ABUSE HISTORY

1. What kind(s) of alcohol do you drink? _____

2. How often do you drink? _____

3. Has your drinking ever been an issue between you and your family or friends? Yes No

4. Are you currently in or have you ever received treatment for alcohol abuse? Yes No

IF YES, please check all applicable treatment:

Counseling/Therapy Detox Rehab Inpatient Rehab Outpatient AA/NA

5. If a box was checked, please list, in chronological order, the therapist/agency/hospital utilized:

Date:	Therapist/Hospital:	Complete mailing address:	Telephone number:

6. Drug use history:

Name of drug:	How often:	Age of first use:	Date of last use:

7. Prescription drug use history:

Name of drug / # milligrams:	How often taken:	Prescribing doctor:	Doctor's phone number:

Do you have a medical marijuana card? Yes No Expiration Date: _____

Have drugs or alcohol ever caused you to lose a job? Yes No

Has your drug use ever been an issue between you and your family and friends? Yes No

Have you ever been court ordered for drug testing? Yes No IF YES, When::: _____

Were the results of the drug tests positive? For what drugs? _____

SECTION 9: CHILD(REN)'S INFORMATION:

NAME OF CHILD #1: _____

Who do they live with? _____

Child's DOB: _____ Age: _____ Grade Level: _____

School/Daycare Name: _____

School/Daycare Address: _____

School/Daycare Telephone#: _____

Teacher/Daycare Provider Name: _____

Principal Name: _____

Pediatrician Name: _____

Pediatrician's Address: _____

Pediatrician's Telephone #: _____

- Does this child presently have physical or emotional problems? Yes No
IF YES, what is the issue? _____

- Is this child presently in individual counseling or children of divorce group? Yes No

Professional's/Agency Name: _____

Therapist's Address/phone #: _____

NAME OF CHILD #3: _____

Who do they live with? _____

Child's DOB: _____ Age: _____ Grade Level: _____

School/Daycare Name: _____

School/Daycare Address: _____

School/Daycare Telephone #: _____

Teacher/Daycare Provider Name: _____

Principal Name: _____

Pediatrician Name: _____

Pediatrician's Address: _____

Pediatrician's Telephone #: _____

- Does this child presently have physical or emotional problems? Yes No
IF YES, what is the issue? _____

- Is this child presently in individual counseling or children of divorce group? Yes No

Professional's/Agency Name: _____

Therapist's Address/phone #: _____

NAME OF CHILD #2: _____

Who do they live with? _____

Child's DOB: _____ Age: _____ Grade Level: _____

School/Daycare Name: _____

School/Daycare Address: _____

School/Daycare Telephone#: _____

Teacher/Daycare Provider Name: _____

Principal Name: _____

Pediatrician Name: _____

Pediatrician's Address: _____

Pediatrician's Telephone #: _____

- Does this child presently have physical or emotional problems? Yes No
IF YES, what is the issue? _____

- Is this child presently in individual counseling or children of divorce group? Yes No

Professional's/Agency Name: _____

Therapist's Address/phone #: _____

NAME OF CHILD #4: _____

Who do they live with? _____

Child's DOB: _____ Age: _____ Grade Level: _____

School/Daycare Name: _____

School/Daycare Address: _____

School/Daycare Telephone #: _____

Teacher/Daycare Provider Name: _____

Principal Name: _____

Pediatrician Name: _____

Pediatrician's Address: _____

Pediatrician's Telephone #: _____

- Does this child presently have physical or emotional problems? Yes No
IF YES, what is the issue? _____

- Is this child presently in individual counseling or children of divorce group? Yes No

Professional's/Agency Name: _____

Therapist's Address/phone #: _____

SECTION 10: YOUR OPINION OF THE OTHER PARENT

1. In what ways is the other parent a good parent?

2. In what ways is the other parent **not** a good parent? _____

3. What parenting responsibilities did each parent have in the past? _____

4. What is the other parent's relationship with each child? (For example, Close? Strained? None? Needs improvement?) _____

5. Has the other parent's relationship with each child changed over time? How has it changed? _____

6. What does the other parent need to do to be a better parent? _____

SECTION 11: YOUR RELATIONSHIP WITH EACH CHILD *(additional pages attached if more than one minor)*

1. Please describe each child (check off and circle those that apply):

a. Activity level: high energy low energy

b. Attention: able to focus easily distracted

c. Level of intensity when upset: reacts dramatically becomes quiet

i. Gets hungry or tired: at predictable times at unpredictable times

ii. Response to stimulation: startles easily to sounds remains calm

iii. Appetite: picky eater will eat anything

iiii. Adaptability: approaches new situations easily takes a long time to become comfortable

a. When faced with obstacles (example: putting together a puzzle):

child is patient child gives up easily

b. Mood in general: the child is positive and happy the child focuses on the negative

2. What does each child do well? *(additional pages are attached if more than 1 child and if more space is needed for response)*

3. What kinds of problems does each child have (Social, emotional, intellectual)? *(additional pages attached for response)*

4. What have you done to try to help each child with these problems? _____

5. Describe special interests and/or activities that you and each child share: _____

6. What kind of discipline works with each child? _____

7. When you and each child talk about the other parent, what do you say? _____

SECTION 12: YOUR FAMILY BACKGROUND AND OTHER INFORMATION

1. What are/were your parents'/stepparents' names and occupations?

2. What are your siblings' names? What place are you in the birth order? _____

3. Who lived with you growing up? What role did they play in your life? _____

4. What was the quality of your parents' relationship with each other growing up? What is it like now?

5. Did your parents divorce? If so, who did you live with? What effect did the divorce have on you?

6. Were there any issues in the home growing up such as substance abuse or mental health issues?

7. What is your current relationship with each of your siblings? (for example, Close? Strained? None? Needs improvement?) _____

8. What issues, if any, did you experience during your early adulthood in school, with peers, with substance abuse or mental health? _____

9. What was the parenting role of your mother and your father growing up? _____

SECTION 13: PLEASE LIST THE NAMES AND BIRTHDATES OF ALL OTHER ADULTS LIVING IN THE HOME:

SECTION 14: DOMESTIC VIOLENCE HISTORY

1. Has there ever been domestic violence involving you and the other parent? Yes No IF YES, when did the domestic violence occur? Within the past year 1 to 5 years ago More than 5 years ago
2. If there has been domestic violence over the past year, have the frequency of incidents:
 Decreased Increased Remained the same
3. Is there a current protective order or restraining order? Yes No
 - a. IF YES, what kind? Criminal Stay away Peaceful Contact Allowed
 - b. When does the protective order or restraining order expire? _____
4. If there has been domestic violence, has the other parent done or threatened to do any of the following to you:

Pushing, shoving, grabbing or restraining you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Slapping you with an open hand?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hitting with a closed hand or fist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulling your hair?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physically dragging or throwing you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biting or kicking you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hitting you in the head, face or elsewhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Using an object to hit you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Choking, strangulating or smothering you?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disabling or withholding your phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Following you or having someone else do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Were any weapons ever involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Demanding knowledge of your whereabouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any police reports?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Keeping you away from family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disabling your car; withholding keys?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Were the children present for any domestic violence incident? Yes No
6. Did you ever seek medical attention because of domestic violence? Yes No
7. Are there any police reports regarding domestic violence between you and the other parent? Yes No
8. Has the other parent ever threatened to harm the child/ren? Yes No
9. Has the Court ever ordered the other parent to complete a batterer's treatment program? Yes No Don't know
10. Have you been "warned" by the other parent not to say certain things during mediation? Yes No
11. Are you afraid of the other parent for any reason? Yes No
12. Are you concerned there will be future incidents of domestic violence with the other parent? Yes No

SECTION 15: IS THERE ANYTHING ELSE YOU WOULD LIKE THE INVESTIGATOR TO KNOW?
