

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



WARD LAW LLC
KANSAS FAMILY LAW™

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: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

May we leave a message with your emergency contact if we are unable to reach you? Yes No

INCOME INFORMATION

Please attach copies of each: Last Three (3) paystubs Last W-2/1099 Last Tax Return

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

Deductions: Withholding: Single Married # of Dependents Claimed: _____

Federal Withholding: \$ _____ Medicare: \$ _____ Social Security: \$ _____ State Withholding: \$ _____

Health Insurance: \$ _____ Life Insurance: \$ _____ Other Deductions: \$ _____

Monthly Net Wages: \$ _____

Pay Frequency: Weekly Bi-Weekly Monthly Semi-Monthly Other: _____

Please list all bonuses you have received in the last 24 months \$ _____.

Please list all commissions you have received in the last 24 months \$ _____.

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

Other Income (e.g. second job, disability, retirement pay, VA Pension, Social Security, freelance work, etc.): _____

Custody | Parenting Time Questionnaire

OPPOSING PARTY

Full Legal Name: _____ SSN# _____

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

Date of Birth: _____ Age: _____ Gender: Male Female

Place of Birth (county or state): _____

Please mark preferred phone number below.

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

Preferred Email: _____

Physical Description (identifying features: height, hair color, eye color, tattoos, etc.): _____

Automobile Make, Model and Color (include license plate number if known): _____

Current Employer: _____ Current Position: _____

Employer Address: _____ Employer Phone: _____

Attorney's Name: _____

INCOME INFORMATION

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CHILDREN

Number of children: _____

Child's Name (first, middle, last)	Date of Birth (MM/DD/YYYY)	Social Security Number (Full SSN)	Gender	Still Living at Home	Are they of Native American Heritage?
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> M <input type="checkbox"/> F	<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:

Dates: _____ City: _____ State: _____

Dates: _____ City: _____ State: _____

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 Ex
		<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 Ex
		<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 Ex

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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)

Please provide a copy of Employee and Family Premium Cost Sheet.

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 _____

What is the monthly cost for each of the following to the parent:

Parent/Employee Only \$_____ Parent + Spouse \$_____

Parent + Child(ren) \$_____ Entire Family \$_____

Have you or the other party signed up for the Affordable Care Act (ACA) exchange? Yes No

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

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DOMESTIC VIOLENCE/MENTAL HEALTH

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

Have you ever filed a Protection From Abuse (PFA)? Yes No

Have you ever had a Protection From Abuse(PFA) filed against you? Yes No

ADDITIONAL INFORMATION: