

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



Grandparent Custody | Visitation Request Questionnaire

OUR CLIENT

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: _____

Race: _____ Maiden Name: _____ or Former Name: _____

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: _____

Race: _____

MOTHER'S INFORMATION

Full Legal Name: _____ SSN# _____

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

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

Place of Birth (county or state): _____

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

Email: _____ Race: _____

Maiden Name: _____ or Former Name: _____

FATHER'S INFORMATION

Full Legal Name: _____ SSN# _____

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

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

Place of Birth (county or state): _____

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

Email: _____ Race: _____

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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:

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: _____

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

Dates: _____ City: _____ State: _____

Dates: _____ City: _____ State: _____

Has there been 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): _____

PARENTING TIME/GRANDPARENT VISITATION

Who has primary residency? _____

CASE INFORMATION

Case No. _____

Mother's Attorney: _____

Father's Attorney: _____

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Describe relationship between grandparent(s) and child(ren): _____

Describe reasons why parent has not allowed contact with child(ren): _____

Describe last contact with child(ren): _____

Describe contact with child(ren) historically before contact was stopped by parent: _____

What would you propose regarding grandparent visitation and contact with the child(ren)?: _____

Describe your home, employment and any other factors that could affect grandparent visitation: _____

If you have had involvement with the Court system regarding this issue in the past, please describe it in detail: _____

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DOMESTIC VIOLENCE/MENTAL HEALTH

Are the children in a relationship in which they have been physically hurt or threatened by either parent? Yes No

Has either parent ever threatened or abused the children mentally or physically? Yes No

Do you believe either parent/significant other abuses alcohol? Yes No

Does either parent/significant other believe you abuse alcohol? Yes No

Do you believe you abuse alcohol? Yes No

Do you believe either parent/significant other abuses prescription or illegal drugs? Yes No

Does either parent/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 either parent/significant other has a mental health problem or issue? Yes No

Does either parent/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: