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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 Belaire Counseling Services, LLC 5536 Superior Dr. Suite B, Baton Rouge, LA 70816. I acknowledge that I received a copy of the HIPAA Privacy Notice.

Signature

Date

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
2	Feeling timid or shy	1	2	3	4	5
3	Feeling depressed	1	2	3	4	5
4	Being easily embarrassed	1	2	3	4	5
5	Feeling like a failure	1	2	3	4	5
6	Feeling on the verge of tears	1	2	3	4	5
7	Being ill at ease with others	1	2	3	4	5
8	Feeling discouraged	1	2	3	4	5
9	Not feeling like eating	1	2	3	4	5
10	Lacking friends	1	2	3	4	5
11	Feeling shy with the opposite sex	1	2	3	4	5
12	Blaming, criticizing or condemning others	1	2	3	4	5
13	Difficulty holding conversations	1	2	3	4	5
14	Feeling hopeless	1	2	3	4	5
15	Having headaches	1	2	3	4	5
16	Difficulty sleeping	1	2	3	4	5
17	Staying by yourself a lot	1	2	3	4	5
18	Feeling tense and nervous	1	2	3	4	5
19	Upset stomach	1	2	3	4	5
20	Sexual problems	1	2	3	4	5
21	Suicidal thoughts	1	2	3	4	5
22	Problems with family	1	2	3	4	5
23	Upset by academic concerns	1	2	3	4	5
24	Problems with spouse or significant other	1	2	3	4	5
25	Stress related to work	1	2	3	4	5
26	Stress related to school	1	2	3	4	5
27	Being overweight	1	2	3	4	5
28	Problems with anxiety	1	2	3	4	5
29	Unhappy with living arrangements	1	2	3	4	5

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.