

Please fill out this form carefully, completely and return to:

Donald LaFave Mediation & Counseling, LLC
316-5th Sreet, Suite 3
Post Office Box 113
Racine, WI 53401-0113

SOCIAL HISTORY INFORMATION

A. IDENTIFYING DATA

Your Present Name and Case No: _____
(Include initial or suffix)

Other Parents Name: _____
(Include initial or suffix)

Your Age: _____ Date of Birth: _____ Place of Birth: _____

Your Home Address: _____
(Include city, state & zip)

Your Home Phone: _____ Cell Phone: _____

Your Social Security#: _____ Driver License#: _____

Your Attorney: _____ Attorney's Phone: _____

Previous Residences in past 5 years: _____

(Use reverse side if needed)

Do you expect to change residences within the next 12 months? If yes, please explain: _____

(Use reverse side if needed)

B. EMPLOYMENT

Employer: _____ Phone: _____

Position: _____ Wages: _____

Employment Length: _____ Work schedule: _____
(Include hours/days)

Past Employers, dates of employment, and reasons for leaving: _____

(Use reverse side if needed)

C. CHILDREN (Name all children, including adult children)

<u>Name</u>	<u>Sex</u>	<u>Date of Birth</u>	<u>Parent Having Placement</u>	<u>School/Grade</u>	<u>Teacher</u>
_____	M F	_____	_____	_____	_____
_____	M F	_____	_____	_____	_____
_____	M F	_____	_____	_____	_____
_____	M F	_____	_____	_____	_____
_____	M F	_____	_____	_____	_____

D. PERSONALITY DESCRIPTIONS

Minor Child(ren) : _____

(Please enclose a picture of yourself and your child(ren))
Child(ren)'s Special Emotional or Physical Needs (include names,
addresses, and phone numbers of current and previous counselors): _____

(Use reverse side if needed)

School History for each Child (performance, social adjustment,
grade level, etc.): _____

(Please attach the latest school report card for each child)

E. MARITAL/RELATIONSHIP HISTORY

List all your marriages:

<u>Name of Spouse</u>	<u>Date of Marriage</u>	<u>Date & How Terminated</u>	<u>Number of Children</u>
First _____			
Second _____			
Third _____			
Fourth _____			

Are you remarried: YES NO

If Yes, please give name: _____
(Include initial or suffix)

If No, are you contemplating marriage: YES NO

If Yes, please give name: _____
(Include initial or suffix)

Describe Marital/Relationship History with Parent in Dispute With: _____

Met: _____

Married/Lived Together: _____

Breakup: _____

Separated from Other Parent (when and why): _____

Responsibility for Care of Children During Marriage/Relationship: _____

F. YOUR FAMILY OF ORIGIN

Born and Raised (where you were born and raised): _____

Your Mother (describe occupation and relationship): _____

Your Father (describe occupation and relationship): _____

Your Brothers and Sisters (age and relationship): _____

Your Parents (describe their relationship with each other): _____

Psychiatric History for Self and Family of Origin: _____

Alcohol Abuse for Self and Family of Origin: _____

Drug Abuse for Self and Family of Origin: _____

Arrests/Criminal History for Self and Family of Origin: _____

G. PERSONAL DATA

Education (give highest degrees): _____

Military History: _____

Medical History (include name of your physician): _____

Prescribed Medication and what it is used for: _____

(Use reverse side if needed)

Hospitalization History: _____

Psychiatric: _____

Alcohol/Drug Use: _____

Psychotherapy: (psychotherapists and dates of treatment): _____

Other Concerns (i.e., sexual abuse, romances, drug abuse, alcohol abuse, irresponsibility in Yourself):

Other Concerns (i.e., sexual abuse, romances, drug abuse, alcohol abuse, irresponsibility in Other Parent:

1) Have you ever experimented with or used the following substances:

- | | YES | NO |
|---|--------------------------|--------------------------|
| a) Alcohol, more than 8 drinks in a day | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Marijuana or cannabis in other forms | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Cocaine | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Amphetamines | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Hallucinogens | <input type="checkbox"/> | <input type="checkbox"/> |

2) Have you or any of your family (parents, brothers/sisters, aunts/uncles, grandparents) had the following:

- | | YES | NO |
|----------------------------------|--------------------------|--------------------------|
| a) Manic-depressive disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Schizophrenia | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Obsessive-compulsive disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Autism | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |

3) Have you ever been:

- | | YES | NO |
|--|--------------------------|--------------------------|
| a) dishonorably discharged from the military | <input type="checkbox"/> | <input type="checkbox"/> |
| b) arrested for any reason whatsoever | <input type="checkbox"/> | <input type="checkbox"/> |
| c) investigated for alleged child abuse or neglect | <input type="checkbox"/> | <input type="checkbox"/> |
| e) subject to physical, sexual or verbal abuse | <input type="checkbox"/> | <input type="checkbox"/> |

4) Have you disagreements or concerns with the other parent concerning the child(ren) and the following issues:

- | | YES | NO |
|--|--------------------------|--------------------------|
| a) Educational decisions | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Non-Emergency medical care decisions | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Religion or religious upbringing decisions | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Extra curricular, sporting, cultural or social activity decisions | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Driver license authorization | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Permission to marry as a minor | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Permission to enter the military as a minor | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Other issues: _____ | | |

(Specify)

H. STEPPARENT OR SIGNIFICANT OTHER

If you have been remarried or if you now share or plan to share your home with another adult, please complete the following information regarding the other adult:

Name: _____
(Include initial or suffix)

Age: _____ Date of Birth: _____ Place of Birth: _____

Social Security#: _____ Driver License#: _____

Address: _____
(Include city, state and zip)

Employer: _____ Position: _____

Employment Length: _____ Work Schedule: _____
(Include hours/days)

Relationship to You: _____

Relationship with the Child(ren) at Issue: _____

I REFERENCES

List the names, addresses, including zip codes, and telephone numbers of people familiar with you as a parent and whom you wish to be contacted:

Name	Address	Phone
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Use reverse side if needed)

COMMENTS:

(Signature) Dated: _____