

PAUL SCOTT & ASSOCIATES

CLIENT QUESTIONNAIRE

HOW DID YOU HEAR ABOUT US? (CIRCLE ONE)

WEBSITE ☐ FACEBOOK ☐ GOOGLE ☐ REFERRAL _____ OTHER _____

CLIENT INFORMATION

FullName(First/Middle/Last): _____

Address: _____

Phone: _____ Email: _____

Employer: _____ Position: _____

Employer Address: _____

Phone: _____

Gross Weekly Income: _____ Income reported on last year's taxes: _____

County Residing In: _____ Length of Residence in State: _____

Driver's License # _____ Date of Birth: _____

Place of Birth (City, State): _____

Level of Education (Check One): HS ☐ BA/BS ☐ MASTERS ☐ PhD/DOCTORATE ☐

Social Security Number: _____

PLEASE LIST ANY:

Criminal Convictions: _____

Alcohol/Drug Abuse: _____

Domestic Violence: _____

Anything else we should know? Please describe: _____

OTHER PARTY INFORMATION

FullName(First/Middle/Last): _____

Address: _____

Phone: _____ Email: _____

Employer: _____ Position: _____

Employer Address: _____

Phone: _____

Gross Weekly Income: _____ Income reported on last year's taxes: _____

County Residing In: _____ Length of Residence in State: _____

Driver's License # _____ Date of Birth: _____

Place of Birth (City, State): _____

Level of Education (Check One): HS ☐ BA/BS ☐ MASTERS ☐ PhD/DOCTORATE ☐

Social Security Number: _____

PLEASE LIST ANY:

Criminal Convictions: _____

Alcohol/Drug Abuse: _____

Domestic Violence: _____

Anything else we should know? Please describe: _____

CHILDREN

Full Name (First/Middle/Last)	Birthdate	School/Grade	Social Security Number
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If separated, state the current parenting time routine and for how long:

ANY OTHER MINOR CHILDREN RESIDING WITH EITHER PARTY:

Full Name (First/Middle/Last)	Birthdate	Residential Address	Whose Child
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_____	_____	_____	_____
_____	_____	_____	_____

HEALTH INSURANCE INFORMATION FOR CHILDREN:

Name of children: _____

Name of Policy Holder: _____

Name of Insurance CO/HMO: _____

Policy/Certificate/Contract No: _____

OTHER INSURANCE:

Name of children: _____

Name of Policy Holder: _____

Name of Insurance CO/HMO: _____

Policy/Certificate/Contract No: _____

OTHER TYPES OF INSURANCE AN PREMIUMS PAID:

HAS EITHER PARTY APPLIED FOR OR ARE RECEIVING PUBLIC ASSISTANCE? IF YES:

WHO IS RECEIVING	TYPE OF ASSISTANCE (Bridge card, Medicaid, etc.)	CASE #
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_____	_____	_____
_____	_____	_____

IMPORTANT

IF YOU DO NOT WISH TO HAVE ANY MAIL SENT TO YOUR ADDRESS, SIGN HERE:

Signature: _____

Print Name: _____ Date: _____

IF SO, WE NEED AN ALTERNATE ADDRESS IN THE MEANTIME (I.E., FAMILY MEMBER, FRIEND, OR WORK). PLEASE PROVIDE:

Address: _____ **City:** _____

State: _____ **Zip:** _____

IF YOU PREFER COURT DOCUMENTS TO BE SENT BY EMAIL, PLEASE PROVIDE:

Email Address: _____