WESTHAMPTON FAMILY PSYCHOLOGISTS, P.C.

CO-PARENTING REGISTRATION FORM

ALL INFORMATION WILL BE TREATED CONFIDENTIALLY.

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PREFERRED PHONE CONTACT (CIRCLE): HOME CELL WORK EMAIL: _____

OK TO LEAVE PHONE MESSAGE ON FOLLOWING NUMBERS? (CIRCLE): HOME CELL WORK

DATE OF BIRTH: _____ AGE: _____ GENDER: M F RACE: _____

MARITAL STATUS: _____

HIGHEST EDUCATION LEVEL: _____

OCCUPATION: _____

EMPLOYER: _____

ESTIMATED HOUSEHOLD INCOME: _____

PLEASE RECORD THE FOLLOWING INFORMATION ABOUT YOUR CHILD(REN) – PLEASE INCLUDE ANY CHILD THAT LIVES WITH YOU FOR ANY PERIOD OF TIME:

NAME	DOB	GENDER	GRADE IN SCHOOL	B = BIOLOGICAL, A = ADOPTED, S = STEPCHILD

Date of Marriage to Co-Parent (MM/YY): _____

Date of Separation from Co-Parent (MM/YY): _____ _____

Date of Divorce from Co-Parent (MM/YY): _____

Age(s) of Children at Separation: _____

Was this your first divorce? Y N If No, How many times have you been divorced? _____

Have you Remarried since the divorce? Y N If Yes, When (MM/YY)? _____

In the past year, have you and your co-parent been involved in any legal proceedings regarding custody, visitation, or child support issues? Y N If Yes, Did you go to court over this matter? Y N

Approximately how many times have you been to court over custody, visitation, or child support issues? _____

CUSTODY ARRANGEMENT:

Who has legal Custody? YOU OTHER PARENT JOINT

Who has Physical Custody? YOU OTHER PARENT JOINT

Which parent do your child(ren) spend the most time with? YOU OTHER PARENT ABOUT EQUAL

Describe Visitation Schedule: _____

_____

_____

CURRENT TREATMENT PROVIDERS/PROFESSIONALS:

Therapist: _____ Agency: _____ Phone: _____

Psychiatrist: _____ Agency: _____ Phone: _____

Attorney: _____ Phone: _____

GAL: _____ Phone: _____

Child Therapist: _____ Agency: _____ Phone: _____

Child Psychiatrist: _____ Agency: _____ Phone: _____

Other: _____ Agency: _____ Phone: _____

Other: _____ Agency: _____ Phone: _____

In Case of Emergency, Notify: _____ Relationship: _____ Phone: _____

Who Referred You? _____ Relationship: _____

By Signing Below, I attest that the information I have provided on this form is accurate, to the best of my knowledge.

_____

Patient Signature Date