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**GUARDIAN AD LITEM & CHILD'S REPRESENTATIVE INTAKE  
FORM**

**PLEASE CIRCLE ONE:**                      MOTHER                      FATHER                      GUARDIAN

**YOUR INFORMATION**

Full Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Future (new) address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

S.S. #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Average Work Schedule: \_\_\_\_\_

Telephone Numbers:

Office: \_\_\_\_\_ ext: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Home: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Cell: \_\_\_\_\_ Other Numbers: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you Married/Remarried? (Please Circle)                      YES                      NO

If so, New Spouse's Name: \_\_\_\_\_

Are you Living with Anyone? (Please Circle)                      YES                      NO

If so, Please List: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Length of time a Resident of Illinois: \_\_\_\_\_

Education completed: \_\_\_\_\_

Religion/Ethnicity: \_\_\_\_\_

Closest Relative Name and Relationship: \_\_\_\_\_

Closest Relative Address: \_\_\_\_\_

Your health: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Under treatment for: \_\_\_\_\_

Emergency Contact Name/Number/Relationship: \_\_\_\_\_

**CHILDREN'S INFORMATION**

<u>Full Name</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Social Security Number</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

With Whom Does Each Child Live? \_\_\_\_\_

Addresses for Each Child: \_\_\_\_\_

Physical or emotional disabilities of child(ren): \_\_\_\_\_

What Schools are the Children Attending, if any? \_\_\_\_\_

What is the Name, Address and Phone Number of the Daycare Provider(s), if any? \_\_\_\_\_

Are any of the Children seeing a Therapist/Counselor/Psychologist/Psychiatrist? YES NO

If so, Please List the Name and Phone Number: \_\_\_\_\_

Please list the addresses that the children have resided in, with whom, and the dates the children resided at each location for the previous five (5) years:

<u>Address</u>	<u>With</u>	<u>When</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**OTHER PARENT'S INFORMATION**

Full Legal Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

S.S. #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Age: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Average Work Schedule: \_\_\_\_\_

Telephone Numbers:

Office: \_\_\_\_\_ ext: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Home: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Cell: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is he/she Remarried? (Please Circle)      YES                      NO

If so, New Spouse's Name: \_\_\_\_\_

Is he/she Living with Anyone? (Please Circle)      YES                      NO

If so, Please List: \_\_\_\_\_

\_\_\_\_\_

Place of Birth: \_\_\_\_\_ Length of time a Resident of Illinois: \_\_\_\_\_

Education completed: \_\_\_\_\_

Religion/Ethnicity: \_\_\_\_\_

Future (new) address: \_\_\_\_\_

His/Her Health: \_\_\_\_\_

Under treatment for: \_\_\_\_\_

\_\_\_\_\_

**SUMMARY OF ISSUES**

Please Briefly State the Reason that you are Here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please Briefly State your Goals and/or Desired Outcome: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_