The Law Offices of Shelly B. West
Three Energy Square
6688 North Central Expressway, Suite 1000
Dallas, Texas 75206
214-373-9292
www.edallasattorney.com

consult $_____

SUIT AFFECTING THE PARENT-CHILD RELATIONSHIP INFORMATION SHEET

Date of Consultation: _____ Referred by: _____
(today's date) (who referred you to our office, i.e., name of friend, attorney, or internet referral)

PETITIONER: (Petitioner is the person who is filing the case).

Full Name: _____ **Age: _____ Race: _____**

Maiden Name: _____ **Social Security# (last 4 digits only) _____**

Birthdate: _____ **D.L. # (last 4 digits only) _____ State: _____**

Place of Birth: _____

Home Address & County:_____

Telephone Numbers: **(Work): _____** **(Home): _____**

Other numbers: **(Cell): _____** **(Fax): _____**

Business Name: _____

Business Address: _____

Email Address: _____

Salary/Income: _____

RESPONDENT: (Respondent is the person who the case is being filed against).

Full Name: _____ **Age: _____ Race: _____**

Maiden Name: _____ **Social Security# (last 4 digits only) _____**

Birthdate: _____ **D.L. # (last 4 digits only) _____ State: _____**

Place of Birth: _____

Home Address & County:_____

Telephone Numbers: **(Work): _____** **(Home): _____**

Other numbers: **(Cell): _____** **(Fax): _____**

Business Address: _____

Email Address: _____

Salary/Income: _____
_____

Your Next of Kin: _____ **Phone:** _____
_____

CHILDREN FROM THE RELATIONSHIP:

Name	S.S. Number (last 4 digits only)	Sex	Birthdate	Birthplace
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

_____

_____ **Temporary Orders Desired?**
_____ **Extraordinary Relief Desired?** _____
_____ **Request Award of Attorney's Fees?**
_____ **Waiver or Service?**
_____

Are you seeking full custody, partial custody or visitation? _____

Why are you pursuing this matter? _____

_____

Who is/are the child(ren) living with now and for what period of time: _____

_____

What are you seeking to change? Check all that apply:

_____ **Raise child support**
_____ **Lower child support**
_____ **Get health insurance for child(ren)**
_____ **Get dental insurance for child(ren)**
_____ **Obtain reimbursement for medical expenses**
Who will pay _____ you _____ or the other party?
_____ **Change visitation**
More time with kids for you _____
More time with kids for other party _____
Change visitation to something else _____
_____ **Change custody**
Custody for you _____
Custody for other party _____
Change custody to joint custody _____
Change visitation to something else _____
_____ **Domicile restriction**
Lift it _____
Impose a domicile restriction _____
_____ **Other changes. Please explain:** _____

_____

Have you been to court before in this matter? _____

When and Why? _____

_____

_____

Cause No. (Case No.) and County of case _____
(Please provide the latest order, if any.)

How many attorneys have you had? _____

Have you ever been charged or convicted with a misdemeanor? If yes, please explain _____

_____

_____

_____

Have you ever been charged or convicted with a felony? If yes, please explain _____

_____

_____

_____

At what age did you graduate from high school? _____

NO. _____

	§	**IN THE DISTRICT COURT**
_____	§	**_____ JUDICIAL DISTRICT**
_____	§	**_____ COUNTY, TEXAS**

FINANCIAL INFORMATION STATEMENT

(Required in All Financial Hearings)

MONTHLY EXPENSES	PRESENT
HOUSING	
House Mortgage/Rent	_____
Utilities	
(Gas, water, etc.)	_____
Maintenance & Repair	_____
Other _____	_____
TRANSPORTATION	
Car Payment/Lease	_____
Gas, Oil, Maintenance	_____
Parking & Tolls	_____
INSURANCE	
Auto	_____
Life	_____
Medical	_____
Other _____	_____
GROCERIES	
Food & Household Supplies	_____
YOUR PERSONAL	
Work Expenses:	
Lunches, etc.	_____
Dues, Fees, etc.	_____
Medical Expenses	
(not paid by ins):	
Drugs	_____
Doctors, Dentists	_____
Clothing	_____
Cleaning, Laundry	_____
Grooming	_____
Entertainment	_____
Current Child Support	_____
Other:	
_____	_____
_____	_____
CREDIT CARD/DEBTS	
_____	_____
_____	_____
Monthly Attorney Fees	_____

MONTHLY EXPENSES (cont.)	PRESENT
YOUR CHILDREN	
Child Care	_____
School Tuition, Fees	
Lunches	_____
Supplies	_____
Medical Expenses	_____
(not covered by ins)	
Drugs	_____
Doctors, Dentists	_____
Grooming	_____
Entertainment	_____
Sports, Lessons, etc.	
Other: _____	_____
_____	_____
_____	_____
TOTAL EXPENSES	_____

_____

INCOME: (attach current pay stubs)

[ ] paid monthly [ ] paid semi-monthly

[ ] paid weekly [ ] paid every two weeks

_____

GROSS INCOME

DEDUCTIONS	_____
Withholding Tax	_____
FICA	_____
Mandatory Retirement	_____
Medical Insurance	
Children	
Other Family	_____
Life Insurance	_____
Other	_____
OTHER	_____
LIQUID ASSETS	_____

_____

I hereby certify that the answers to the above questions as listed are true and correct.

_____ Date _____ Signed

CAUSE NO. _____

IN THE MATTER OF (INTEREST OF)	§	IN THE DISTRICT COURT
_____	§	
	§	OF DALLAS COUNTY, TEXAS
AND	§	
_____	§	_____ JUDICIAL DISTRICT

HEALTH INSURANCE AVAILABILITY FORM

Attention: This information must be filed with the court BEFORE first hearing.
See TEX FAM CODE § 154.181(b).

NAME OF PARTY: _____ ☐ MOVANT ☐ RESPONDENT

PARTY'S ATTORNEY (IF ANY): _____

BESIDE THE NAME OF EACH CHILD, CHECK ALL TYPES OF HEALTH INSURANCE OR HEALTH CARE BENEFITS CURRENTLY COVERING THE CHILD(REN). YOU MAY CHECK MORE THAN ONE SOURCE.

			EMPLOYER PROVIDED					
NAME	DOB	SSN (LAST 4 DIGITS)	FATHER'S	MOTHER'S	PRIVATE	CHIP	OTHER	NONE
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐
_____			☐	☐	☐	☐	☐	☐

FOR EACH INSURANCE SOURCE PLEASE LIST THE FOLLOWING INFORMATION:
(ATTACH ADDITIONAL FORMS FOR EACH SOURCE OF BENEFITS)

A. NAME OF CARRIER _____
B. GROUP POLICY ID NUMBER _____
C. POLICYHOLDER NAME & ID NUMBER _____
D. NAME OF COVERED CHILD _____
E. COST/MONTH OF COVERAGE [CHILD{REN) ONLY] $_____
(To determine coverage cost for child(ren), determine total cost for family coverage and subtract from this amount the cost to insure all covered individuals except the children.)

F. ARE YOU CURRENTLY PAYING THE PREMIUMS FOR LISTED MEDICAL BENEFITS? ☐ YES ☐ NO

STATE YOUR NET MONTHLY INCOME FROM YOR FINANCIAL INFORMATION STATEMENT: $_____

_____ _____
SIGNATURE OF PARTY COMPLETING FORM DATE

_____
PRINTED NAME