
FORENSIC COUNSELING SERVICES

Aaron Robb, Ph.D., LPC-S
Program Director

Mailing address:

2831 Eldorado Pkwy, Ste. 103-377, Frisco, TX 75033

Telephone: 972-360-7437

Interview office:

250 N. Mill St. Suite 5, Lewisville (across from City Hall)

Fax: 940-343-2601

www.texascounseling.org

GUARDIAN AD LITEM DATA FORM

Please fill this form out completely. You are responsible for providing updates if any information changes.

Your Name: _____
Last First Middle Maiden/Other names by which you are known

Present

Address: _____
Street Apt. # City State Zip Code

Telephone

Numbers: _____
Home Work Cel Fax

Age: _____ Date of Birth: _____ Drivers License: _____
Number/State

Your relationship to the children in question: Biological Parent Grandparent Stepparent Other: _____

Your Attorney's Name: _____ Legal Assistant: _____

Address: _____
Street City State Zip Code

Telephone Number: _____ Fax Number: _____

Medical History

If any adult involved in the case is taking prescription medication, has any physical disability, chronic medical condition or has received psychiatric, psychological, or other behavioral health treatment, evaluation, or counseling please complete the following information (use additional pages as needed):

| Person | Provider's Name and Address | Telephone | Dates of Treatment |
|--------|-----------------------------|-----------|--------------------|
| | | | |
| | | | |
| | | | |

List any prescription medications you currently take: _____

Does anyone involved in the case have a history of, or been treated for drug or alcohol abuse? Yes No

If yes, please explain: _____

Children: *List the child or children involved in the court action. Use additional pages if needed.*

| Name | Age | Date of Birth | Current allocation of time between parents: |
|------|-----|---------------|---|
| | | | |
| | | | |
| | | | |
| | | | |

Children's Medical Information

Name, address, and telephone number of the children's primary physician:

Have any of the children in question been treated for a current or chronic health problem? Yes No

If yes for what condition and by who? _____

Have any of the children received any behavioral/mental health counseling or treatment? Yes No

If yes for what condition and by who? _____

Special Conditions: _____

Medications: _____

Allergies: _____

Do any individuals stay or live in your home, on full time or part time basis, that are not listed in the above sections of this form? Yes No

If yes, give their names and ages: _____

Criminal History

Have you or any other person involved in the case been arrested, convicted of a felony or misdemeanor, or do they have a police or criminal action pending? Yes No

If yes, please explain: _____

Is any person involved in the case on probation or parole? Yes No

If yes, explain and provide the name, address and telephone number of the probation or parole officer:

Has a protective order been issued against any person involved in the case? Yes No

If yes, please explain: _____

Family Violence

Has there been violence in your relationship? Yes No

If yes how often and over what period of time? _____

Has there been violence or neglect involving the children? Yes No

If yes how often and over what period of time? _____

Has anyone involved in this case ever been involved with Child Protective Services? Yes No

If so, when and in what county? _____

Other Information

Please provide copies of any pertinent court orders or other reports. These may include child custody evaluations, affidavits, records regarding either parent, records regarding the children, correspondence, prior assessments, and other relevant information.