

# FORENSIC COUNSELING SERVICES

## SUPERVISED VISITATION INTAKE 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: \_\_\_\_\_

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

Name	Age	Date of Birth	Resides primarily with:

**Court information:** *Court Number and Cause Number should be at the top of your court order.*

County: \_\_\_\_\_ Court Number: \_\_\_\_\_ Cause Number: \_\_\_\_\_

Is there an Ad Litem or Amicus Attorney assigned?  Yes  No If yes, who? \_\_\_\_\_

Your Attorney's Name: \_\_\_\_\_ Legal Assistant: \_\_\_\_\_

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

Street
City
State
Zip Code

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Other adults involved:** *List the other adult(s) and attorney(s) involved in the litigation. Use additional pages if needed.*

Their name: \_\_\_\_\_ Relationship to children: \_\_\_\_\_

Their address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Their attorney: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Forensic Counseling Services • 2831 Eldorado Parkway, Suite 103-377 • Frisco, TX 75033  
 Telephone 972-360-7437 • Fax 940-343-2601

**Contact Persons:** *Please list at least one emergency contact person other than yourself:*

I hereby authorize Forensic Counseling Services to release the children to the following individuals in an emergency situation when I cannot be reached. I am aware that if I elect not to release my children to any other individuals, or if the individuals listed below do not immediately respond in an emergency, CPS and/or law enforcement will be notified in the event that I cannot be reached. I am aware that persons listed must present valid photo ID upon request before children will be released to them.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Other Emergency Contact Information:**

*Family Pediatrician:*

Name: Dr. \_\_\_\_\_ Emergency contact number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

*Health Insurance:*

Name of Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Phone: \_\_\_\_\_

**Children's Medical Information:**

Please list any special conditions, medications, or allergies that the children may have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Please submit a color copy of your driver's license or government identification card and a clearly labeled picture of the children in question with this form.***

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