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PARENT QUESTIONNAIRE – PARENTING INVESTIGATOR

The purpose of this questionnaire is to assist me as the parenting investigator appointed in your parenting time dispute. Truthful and complete answers will help me conduct a more comprehensive investigation in the most efficient and cost-effective manner possible. The information that you provide will be combined with additional information gathered throughout the investigation process, and then all of the available information will be used to formulate my recommendations to the Court.

It is important to understand that any information obtained by a parenting investigator is not privileged or confidential and will likely be reported to the Court. In turn, the Court may disseminate that information to the other parties, individuals, or professionals associated with your parenting investigator matter.

While completing this questionnaire, please print clearly in black or blue ink. Please answer to the best of your ability. Some of the questions may not apply to you or your family; for those questions, please write “N/A” (not applicable). If you prefer not to answer a question, please make a note of that on the form – **do not leave any questions blank**. If you need more space, use the back of the form or attach a separate sheet of paper. Once completed, please sign and date the last page and remember to mail the questionnaire to me within 7 days of receipt.

Thank You.

Your Personal Information

First Name: _____ Middle Name: _____ Last Name: _____

Maiden Name: _____

Other Name(s) you have been known by: _____

Date of Birth: _____ Place of Birth: _____

Social Security No: _____

Citizenship Status: _____

Religion: _____ Currently active? What activities? _____

Your Relationship to the child(ren) in the case (e.g. mother, stepfather, etc) _____

Current Marital/Coupled Status: _____

When did relationship begin? _____

Date of Marriage: _____

Date of Separation: _____

Date of Divorce: _____

Previous Marriages:

Date of

Marriage: _____ Separation: _____ Divorce: _____

Date of

Marriage: _____ Separation: _____ Divorce: _____

Previous long-term
relationships: _____

Current Address: _____

Describe the type of dwelling that you live in (apartment, house, etc.) _____

How many bedrooms are in the dwelling? _____

Do you rent or own the dwelling? Monthly rent/mortgage? _____

How long have you lived there? _____

Previous 5 Addresses and length of time lived at each address: _____

Current Contact Information for you:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax: _____ Email: _____

Do you have a Facebook or Myspace account? Username? _____

Who Lives (or frequently stays over) at your home? _____

Please describe your current family situation such as birth order, siblings, parents and describe relationships with family members.

Are there any weapons in your home? _____ If yes, what? _____

Where and how stored? _____

Have you ever been issued a permit/license to own/possess a firearm or other type of weapon?

If yes, when and where? _____

Do you own or have access to a legally registered motor vehicle? _____

Describe vehicle _____

Your Parents

(Please provide information even if deceased.)

Mother:

Name: _____ Birthdate: _____ If deceased, at what age? _____

Occupation: _____ Current marital status: _____

Number of marriages: _____

Address: _____

Telephone Number: _____

Any major health problems in your childhood? _____

Father:

Name: _____ Birthdate: _____ If deceased, at what age? _____

Occupation: _____ Current marital status: _____

Number of marriages: _____

Address: _____

Telephone Number: _____

Any major health problems in your childhood? _____

Your SiblingsSibling #1:

Name: _____

Age: _____ Relationship _____

Address: _____

Telephone Number: _____

Occupation: _____

Marital status: _____

How many children? _____

Major health problems? _____

Sibling #2:

Name: _____

Age: _____ Relationship _____

Address: _____

Telephone Number: _____

Occupation: _____

Marital status: _____

How many children? _____

Major health problems? _____

Sibling #3:

Name: _____

Age: _____ Relationship _____

Address: _____

Telephone Number: _____

Occupation: _____

Marital status: _____

How many children? _____

Major health problems? _____

Your Educational History

Elementary School: _____

City/State: _____

Grades Attended: _____ Dates Attended: _____

Middle School: _____ City/State: _____

Grades Attended: _____ Dates Attended: _____

High School: _____ City/State: _____

Grades Attended: _____ Dates Attended: _____

Did you graduate high school? _____ If so, when?: _____

If not, what is highest grade completed? _____

Did you earn a GED? _____ When? _____

College/Technical School and
Degree(s) earned: _____ Date: _____

Please indicate any additional
training/education: _____

Do you have any learning disabilities? If yes, explain: _____

Did you receive any special education services? If yes, provide details: _____

Your Employment and Military History

Are you currently employed _____ If so, where? _____

What is your work telephone number? _____

Immediate Supervisor and phone number: _____

Length of employment: _____ What is your position there? _____

Describe duties: _____

What is your current weekly work schedule? _____

Amount of gross earnings per month? How are they calculated (monthly, weekly)? _____

Briefly list previous employment history (Names, dates of employment, position and reason for leaving): _____

Do you hold any professional licences/certificates? _____

Were you ever in the military? _____ If so, what branch? _____

Rank: _____ Where were you stationed? _____

Describe duties: _____

Dates of service: _____ Discharge status: _____

Additional information: _____

Your Current Financial Situation

Income:

Gross annual income (before taxes): _____

Your spouse/partner's gross annual income (before taxes): _____

Assets:

Your approximate total assets: _____

Your approximate total debt: _____

Do you have any financial concerns? _____

Who primarily handled the finances while you were married/coupled? _____

Your Medical History

Do you have medical insurance? _____ If yes, name of insurance company: _____

Who is your primary care doctor? _____

Date of last routine physical exam: _____

Contact information for doctor: _____

How many pregnancies have you had? _____

How many children have you given birth to? _____

Do you use tobacco? _____ How much daily? _____

Do you drink alcohol? _____ How often do you drink? _____ How much do you drink each time? _____

Do you use any other substances (including "recreational drugs," prescription or over-the-counter medications, etc)? _____

If yes, what type(s)? _____

How often? _____ How much do you use? _____

Have you been diagnosed or treated for any chronic/recurrent medical conditions? _____ If yes, which ones? _____

Have you been diagnosed or treated for any behavioral issues, substance abuse, or mental illnesses? _____

If yes, which ones? _____

Please list any medications you are currently prescribed. (Include name of medication, dosage, and reason prescribed.) _____

Please list any previous hospitalizations. (Include date, hospital, and reason for hospitalization.) _____

Your Family's Medical History

Please indicate which family members (parents, siblings, aunts & uncles, grandparents) have had any of the following:

Diabetes _____ Death at an early age _____

Positive TB test _____ Stomach/Intestinal problems _____

High blood pressure _____	Asthma/Respiratory problems _____
Blood disease/Anemia _____	Psychiatric Problems _____
Heart Attack _____	Substance Abuse/Alcoholism _____
Kidney Problems _____	Epilepsy/Seizures _____
Mental Retardation _____	Trauma _____
Cancer _____	Birth Defects _____
Anxiety/Depression _____	Anger Problems _____
Stroke _____	Family/Domestic Violence _____
Other _____	Other _____

Your History of Therapy and Social Support Services

Please indicate below if you have ever used any services such as individual therapy, couples therapy, or group therapy; Alcoholics Anonymous, Narcotics Anonymous, or Al-anon; psychiatrist; domestic violence services; and state agencies such as Departments of Transitional Assistance, Mental Health, or Mental Retardation.

Have you every been in therapy? _____

If yes, what type? (Individual, marital/couples, family, other)? _____

Provider #1:

Name: _____

Agency/Program: _____

Address: _____

Phone: _____

Type of Services received: _____

Time period: _____

How often (weekly, semi-weekly, etc.): _____

Did you find it helpful? _____

How/Why? _____

Provider #2:

Name: _____

Agency/Program: _____

Address: _____

Phone: _____

Type of Services received: _____

Time period: _____

How often (weekly, semi-weekly, etc.): _____

Did you find it helpful? _____

How/Why? _____

Provider #3

Name: _____

Agency/Program: _____

Address: _____

Phone: _____

Type of Services received: _____

Time period: _____

How often (weekly, semi-weekly, etc.): _____

Did you find it helpful? _____

How/Why? _____

Provider #4

Name: _____

Agency/Program: _____

Address: _____

Phone: _____

Type of Services received: _____

Time period: _____

How often (weekly, semi-weekly, etc.): _____

Did you find it helpful? _____

How/Why? _____

Your History of Legal Involvement and Child Protective Services

Legal Involvement

Have you ever been involved in a civil suit? _____

If yes, please indicate date(s), court(s), and circumstances _____

Have you ever been involved in a Restraining Order? _____ If yes, explain: _____

Have the police ever been to your home? _____ If yes, please indicate date(s), location(s), and circumstances _____

Have you ever been arrested? _____ If yes, please indicate date(s), location(s), and circumstances _____

Do you have a criminal record in this or any other state? _____ If yes, please explain _____

Have you ever been on probation? _____ If yes, when and through what courts? _____

Who was your probation officer? _____

Telephone: _____

What were the conditions of your probation? _____

Have you ever been incarcerated?__ If yes, please indicate date(s), location(s), and circumstances: _____

Mediation

Have you ever participated in mediation? _____ If yes, reason for mediation? _____

How many sessions? _____ What was the resolution, if any? _____

Child Protective Services

Have you (as an adult) or your children ever been involved with Social Services or its equivalent in another state? _____ If yes, please indicate date(s), location(s), and circumstances _____

Who is/was your social worker? _____

Telephone: _____

Have you or your children ever been involved in a Care and Protection or Child in Need of Services matter, or a similar matter in another state? _____ If yes, please indicate date(s), court(s), and circumstances: _____

Any additional information: _____

Your Children**Child #1:**

Name (first, middle, last): _____

Date of birth: _____

Place of birth: _____

Race: _____ Ethnicity: _____

Religion _____

Who is the biological mother? _____

Date of birth: _____

Who is the biological father? _____

Date of birth: _____

Were the parents married at the time of birth? _____

Is biological father named on birth certificate? _____

Where does the child live? _____

Who has primary residential responsibility of the child? _____

Who has legal rights and responsibility of the child? _____

During the pregnancy/birth:

Did the mother use tobacco? ___ Alcohol? ___ Medication? ___ Other substances?: _____

Any complications during pregnancy or birth? _____

Any concerns about child's health after birth? _____

Medical history:

Is child covered by medical insurance? _____

Name of insurance co. _____

Pediatrician: _____

Telephone: _____

Date of last medical visit? _____

When was last routine physical? _____

Is the child up-to-date with routine visits and immunizations? _____

Dentist: _____

Telephone: _____

Date of last dental visit: _____ Date of last routine check-up: _____

Other medical providers or specialists who treat your child: _____

Has the child experienced any of the following medical problems?

Ear infections: _____ Asthma: _____ Heart Murmur: _____ Eczema: _____ Allergies: _____

Any significant medical concerns? _____

School/daycare: _____

Facility name: _____

Address: _____

Contact person: _____

Telephone: _____

How well does the child do in school? _____

Any developmental delays or learning disabilities? _____

Does the child have an individualized education plan (IEP)? _____

What accommodations does the child require? _____

Does the child have any behavioral problems at home, in school, or in the community? _____

What services does the child receive? _____

What are the child's favorite activities? _____

Please describe the child: _____

Please describe your relationship with the child: _____

Any additional information about child #1: _____

Child #2:

Name (first, middle, last): _____

Date of birth: _____

Place of birth: _____

Race: _____ Ethnicity: _____

Religion _____

Who is the biological mother? _____

Date of birth: _____

Who is the biological father? _____

Date of birth: _____

Were the parents married at the time of birth? _____

Is biological father named on birth certificate? _____

Where does the child live? _____

Who has primary residential responsibility of the child? _____

Who has legal rights and responsibility of the child? _____

During the pregnancy/birth:

Did the mother use tobacco? ___ Alcohol? ___ Medication? ___ Other substances?: ___

Any complications during pregnancy or birth? _____

Any concerns about child's health after birth? _____

Medical history:

Is child covered by medical insurance? _____

Name of insurance co. _____

Pediatrician: _____

Telephone: _____

Date of last medical visit? _____

When was last routine physical? _____

Is the child up-to-date with routine visits and immunizations? _____

Dentist: _____

Telephone: _____

Date of last dental visit: _____ Date of last routine check-up: _____

Other medical providers or specialists who treat your child: _____

Has the child experienced any of the following medical problems?

Ear infections: ___ Asthma: ___ Heart Murmur: ___ Eczema: ___ Allergies: ___

Any significant medical concerns? _____

School/daycare: _____

Facility name: _____

Address: _____

Contact person: _____

Telephone: _____

How well does the child do in school? _____

Any developmental delays or learning disabilities? _____

Does the child have an individualized education plan (IEP)? _____

What accommodations does the child require? _____

Does the child have any behavioral problems at home, in school, or in the community? _____

What services does the child receive? _____

What are the child's favorite activities? _____

Please describe the child: _____

Please describe your relationship with the child: _____

Any additional information about child #2: _____

Child #3:

Name (first, middle, last): _____

Date of birth: _____

Place of birth: _____

Race: _____ Ethnicity: _____

Religion _____

Who is the biological mother? _____

Date of birth: _____

Who is the biological father? _____

Date of birth: _____

Were the parents married at the time of birth? _____

Is biological father named on birth certificate? _____

Where does the child live? _____

Who has primary residential responsibility of the child? _____

Who has legal rights and responsibility of the child? _____

During the pregnancy/birth:

Did the mother use tobacco? ___ Alcohol? ___ Medication? ___ Other substances?: _____

Any complications during pregnancy or birth? _____

Any concerns about child's health after birth? _____

Medical history:

Is child covered by medical insurance? _____

Name of insurance co. _____

Pediatrician: _____

Telephone: _____

Date of last medical visit? _____

When was last routine physical? _____

Is the child up-to-date with routine visits and immunizations? _____

Dentist: _____

Telephone: _____

Date of last dental visit: _____ Date of last routine check-up: _____

Other medical providers or specialists who treat your child: _____

Has the child experienced any of the following medical problems?

Ear infections: _____ Asthma: _____ Heart Murmur: _____ Eczema: _____ Allergies: _____

Any significant medical concerns? _____

School/daycare: _____

Facility name: _____

Address: _____

Contact person: _____

Telephone: _____

How well does the child do in school? _____

Any developmental delays or learning disabilities? _____

Does the child have an individualized education plan (IEP)? _____

What accommodations does the child require? _____

Does the child have any behavioral problems at home, in school, or in the community? _____

What services does the child receive? _____

What are the child's favorite activities? _____

Please describe the child: _____

Please describe your relationship with the child: _____

Any additional information about child #3: _____

Child #4:

Name (first, middle, last): _____

Date of birth: _____

Place of birth: _____

Race: _____

Ethnicity: _____

Religion _____

Who is the biological mother? _____

Date of birth: _____

Who is the biological father? _____

Date of birth: _____

Were the parents married at the time of birth? _____

Is biological father named on birth certificate? _____

Where does the child live? _____

Who has primary residential responsibility of the child? _____

Who has legal rights and responsibility of the child? _____

During the pregnancy/birth:

Did the mother use tobacco? ___ Alcohol? ___ Medication? ___ Other substances?: _____

Any complications during pregnancy or birth? _____

Any concerns about child's health after birth? _____

Medical history:

Is child covered by medical insurance? _____

Name of insurance co. _____

Pediatrician: _____

Telephone: _____

Date of last medical visit? _____

When was last routine physical? _____

Is the child up-to-date with routine visits and immunizations? _____

Dentist: _____

Telephone: _____

Date of last dental visit: _____ Date of last routine check-up: _____

Other medical providers or specialists who treat your child: _____

Has the child experienced any of the following medical problems?

Ear infections: _____ Asthma: _____ Heart Murmur: _____ Eczema: _____ Allergies: _____

Any significant medical concerns? _____

School/daycare: _____

Facility name: _____

Address: _____

Contact person: _____

Telephone: _____

How well does the child do in school? _____

Any developmental delays or learning disabilities? _____

Does the child have an individualized education plan (IEP)? _____

What accommodations does the child require? _____

Does the child have any behavioral problems at home, in school, or in the community? _____

What services does the child receive? _____

What are the child's favorite activities? _____

Please describe the child: _____

Please describe your relationship with the child: _____

Any additional information about child #4: _____

Other People for the Investigator to Contact

Please indicate the individuals whom I should contact during the investigation as additional sources of information. Professionals who work or have worked with you and your children are important sources of information and should be included (e.g. medical providers, teachers, therapists). Adult therapists and couples/family therapists are especially useful. In addition, you can identify three other personal references (e.g. neighbor).

The amount of time (and hence cost) involved may limit the number of people I can talk with, so I may not be able to contact everyone you have listed.

Please include all relevant identifying/contact information, including name, address, telephone number, fax number, e-mail address, and relationship to you or your child.

Name: _____
 Relationship to your family: _____
 Address: _____
 Telephone Number: _____
 Fax Number: _____
 Email Address: _____

Name: _____
 Relationship to your family: _____
 Address: _____
 Telephone Number: _____
 Fax Number: _____
 Email Address: _____

Name: _____
 Relationship to your family: _____
 Address: _____
 Telephone Number: _____
 Fax Number: _____
 Email Address: _____

Name: _____
 Relationship to your family: _____
 Address: _____
 Telephone Number: _____
 Fax Number: _____
 Email Address: _____

Name: _____
 Relationship to your family: _____
 Address: _____
 Telephone Number: _____
 Fax Number: _____
 Email Address: _____

Name: _____
Relationship to your family: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Name: _____
Relationship to your family: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Name: _____
Relationship to your family: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Name: _____
Relationship to your family: _____
Address: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____

Preferences Regarding Parental Rights and Responsibilities and Primary Residential Responsibility of Your Children

Please answer each of these items and if necessary, attach additional pages.

1. Where would you like your child to live (primary residential responsibility)? Please state your recommendations for parental rights and responsibilities/parenting time which you feel would serve the best interests of the minor child(ren) _____

2. How would you like to make decisions about your child (parental rights and responsibility)? (Please choose one)

_____ Jointly with the other parent (joint parental rights and responsibilities)

_____ By one parent alone (primary residential responsibility):

_____ Yourself _____ Other parent

3. Reasons for your preferences: _____

4. Describe the circumstances leading up to the present parental rights and responsibilities and parenting time dispute. _____

5. For each of the child(ren) involved in the parental rights and responsibilities dispute, state which parent the child(ren) has lived with from the date of the child(ren)'s birth until the date of the current dispute. _____

6. Since the date of the parental rights and responsibilities/visitation dispute, describe the parental rights and responsibilities/visitation arrangements which have been in place. Include in your answer the dates on which the parental rights and responsibilities/visitation arrangements have changed.

7. Why do you believe that the other party to this action is seeking parental rights and responsibilities/visitation? _____

8. Why do you feel you should have parental rights and responsibilities? Include in your answer the positive qualities or advantages which you believe you can offer the child(ren). Also include in your answer what you believe your main parenting strengths are together with what you perceive to be your parenting weaknesses. _____

9. What role do you believe the noncustodial parent should have in the raising of the child(ren)? _____

10. What, in your opinion, do you believe the other parent's strengths and weaknesses are in terms of their parenting skills? _____

11. Describe any medical/emotional/educational or special needs that your child(ren) have that you believe require special consideration in their placement/parenting time. _____

12. What do you believe are the child(ren)'s preferences with regard to parental rights and responsibilities and parenting time? _____

_____.

13. Describe your feelings regarding the child(ren)'s parenting time with the other parent. Describe what you consider to be the most appropriate visitation schedule, and why. _____

_____.

14. Describe what child care arrangements would be necessary if you were to be granted residential responsibility of the child(ren)? _____

_____.

15. Describe what changes, if any, you intend to make in connection with your employment, address, education, etc., within the next twelve months. _____

_____.

16. Are you now involved in a relationship or contemplating remarriage? If so, state the name of the person with whom you are involved in this relationship. _____

_____.

17. Do you believe that there have been any issues of abuse/neglect involving the child(ren) which you feel are relevant to the issue of parental rights and responsibilities/parenting time? If so, describe those issues. _____

_____.

Signature

I attest that the information in this questionnaire is true to the best of my knowledge and belief. I further understand that any information contained herein may be used within the context of the evaluation by the parenting investigator, will be reported to the Court, and that the Court may make the Report of the Parenting Investigator available to individuals or professionals associated with the legal matter.

Signed under the pains and penalties of perjury on this _____ day of _____, _____.

Parent Signature

Printed Name

Thank you for completing this questionnaire. I appreciate your time, information, and cooperation.

Please be sure to mail the completed questionnaire to me within 7 days of receipt, so I will have time to review it before we meet. If you have any additional documentation or materials you want me to review, please bring photocopies of them to your appointment. I am required to retain a permanent file of all materials that I review for the evaluation, so please do not give me original copies of any personal or family items you would like to have returned.

If you have any questions, please contact me. Email and telephone are the most convenient forms of communication.

Alisha Ankers
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Directions to the Office**FROM THE WEST:**

1. Exit off of I-94 on Exit 343 towards West Fargo
Drive east on Main Avenue (approximately 8 miles)
Turn left on Broadway and drive north
118 Broadway (The Black Building) is located on the left (west) side of the street

Parking is available on the street or in the parking lot west of the building on 2nd Avenue

2. Exit off of I-94 on Exit 349B heading north towards Grand Forks
Travel north on I-29 (approximately 3 miles)
Exit off of I-29 via Exit 65 (Downtown Fargo/West Fargo)
Turn right and head east on Main Avenue
Turn left on Broadway and drive north
118 Broadway (The Black Building) is located on the left (west) side of the street.

Parking is available on the street or in the parking lot west of the building on 2nd Avenue

FROM THE EAST:

1. Exit off of I-94 on Exit 351
Turn right and drive north on University Drive
Turn right on 13th Ave
Turn left on 10th Street
Turn Right on NP Avenue
Turn left on Broadway and drive north
118 Broadway (The Black Building) is located on the left (west) side of the street

Parking is available on the street or in the parking lot west of the building on 2nd Avenue