COMPREHENSIVE EVALUATION QUESTIONNAIRE
JD-FM-95 Rev. 1-14
P.B. § 25-60, and 61

STATE OF CONNECTICUT
SUPERIOR COURT
CSSD-FAMILY SERVICES
www.jud.ct.gov

Instructions

In order to begin the evaluation ordered by the court, you must complete this questionnaire and bring it with you to your first appointment, or mail it to Family Services prior to your first appointment. Please be sure to provide your complete address where requested on this form.

ADA NOTICE

The Judicial Branch of the State of Connecticut complies with the Americans with Disabilities Act (ADA). If you need a reasonable accommodation in accordance with the ADA, contact a court clerk or an ADA contact person listed at *www.jud.ct.gov/ADA*.

Has there been prior involvement with CSSD-Family Services? ☐ Yes ☐ No If Yes, when? _____

Section 1: Identifying Data

Name *(Last, first, middle initial)*	Maiden name	Other names you are known by

Date of birth	Place of birth *(City/town, state, zip)*	Attorney name and telephone number

Telephone numbers *(Home)*	(Work telephone)	(Cell telephone)

Street address

City	State	Zip	How long at this address
			_____ Years _____ Months

Section 2: Current Parenting Plan And Proposed Changes

a.) What is the current parenting plan/access schedule?

b.) How long have these arrangements been in place?

c.) Describe your proposed changes to the existing court-ordered parenting plan. Include a specific parenting plan *(with holidays, summer vacation and school week-long vacations)* for you and the other parent.

d.) How do you and the other parent communicate about child related issues *(e.g., homework, requests to change parenting schedule, extracurricular activities and transportation)*?

e.) How do you think the children are coping with this parenting dispute? What do you think you can do to help them adjust?

f.) What do you believe are the issues currently in dispute between you and the other parent? Please check those issues that have been court-ordered to Family Services for a Comprehensive Evaluation.

- ☐ Relocation of one parent
- ☐ Joint v sole custody
- ☐ Primary residence
- ☐ Major decisions regarding the child/children
- ☐ Access/parenting time or holiday/vacation time
- ☐ Communication between parents
- ☐ Substance abuse issues
- ☐ Mental health issues
- ☐ Domestic violence issues
- ☐ Other: *(Specify)* _____

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DO NOT PLACE THIS DOCUMENT IN THE COURT FILE

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Section 3: Child Information

Please list your children in the boxes below starting with the oldest. If there are more than four children, please attach a separate sheet with the necessary information.

Child's name		
Date of birth	Age	Grade level
School/daycare name		Telephone number
Address		
Teacher/daycare provider name		
Principal name		
Pediatrician name		Telephone number
Address		
Does your child presently have physical or emotional problems?		Yes ☐ No ☐
Is your child presently in individual counseling, therapy or a children of divorce group?		Yes ☐ No ☐
Professional's/agency name		Telephone number
Address		

Child's name		
Date of birth	Age	Grade level
School/daycare name		Telephone number
Address		
Teacher/daycare provider name		
Principal name		
Pediatrician name		Telephone number
Address		
Does your child presently have physical or emotional problems?		Yes ☐ No ☐
Is your child presently in individual counseling, therapy or a children of divorce group?		Yes ☐ No ☐
Professional's/agency name		Telephone number
Address		

Child's name		
Date of birth	Age	Grade level
School/daycare name		Telephone number
Address		
Teacher/daycare provider name		
Principal name		
Pediatrician name		Telephone number
Address		
Does your child presently have physical or emotional problems?		Yes ☐ No ☐
Is your child presently in individual counseling, therapy or a children of divorce group?		Yes ☐ No ☐
Professional's/agency name		Telephone number
Address		

Child's name		
Date of birth	Age	Grade level
School/daycare name		Telephone number
Address		
Teacher/daycare provider name		
Principal name		
Pediatrician name		Telephone number
Address		
Does your child presently have physical or emotional problems?		Yes ☐ No ☐
Is your child presently in individual counseling, therapy or a children of divorce group?		Yes ☐ No ☐
Professional's/agency name		Telephone number
Address		

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Section 4: Living Arrangements

a.) List all adults and children who spend significant time, including overnight stays, in your household:

Name	Date of Birth	Relationship to Self
1)		
2)		
3)		
4)		
5)		
6)		

b.) What are the sleeping arrangements for all of the people in the residence?

c.) Do you rent or own your residence? _____

Section 5: Relevant Marital, Civil Union and Relationship History

	Fill In Approximate	Month	Year
A	Date of marriage or civil union/Start of relationship **with the other parent** in this matter:		
B	Date of separation/End of relationship **with the other parent** in this matter:		
C	Date the divorce or dissolution of civil union was final *(if applicable):*		

Are you remarried, a party to a civil union, living with another person or currently involved in a significant relationship? ☐ Yes ☐ No

If yes, please indicate the name of the person, length of relationship/marriage/civil union and their relationship with your children on the lines below:

Section 6: Education And Employment

Education Level: Please list the highest grade or level of schooling you completed: _____

Schooling: ☐ GED ☐ High School Graduate ☐ College courses taken ☐ College Graduate ☐ Post graduate work

Employment: Are you currently employed? ☐ Yes ☐ No **If yes,** what is your occupation and job location?

How long have you been with your current employer? _____ **Year**(s) _____ **Month**(s)

Current Workday And Hours

☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday

Have you worked consistently for the past five *(5)* years? ☐ Yes ☐ No Who takes care of the children while you are at work?

Weekly Income *(Approximate)*	**Main Income**	**Additional Sources** *(If any)*		**Totals**
Your Weekly Income				**$ 0.00**
Household Weekly Income				**$ 0.00**
Total Income *(From all sources)*				**$ 0.00**

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Section 6: Education and Employment *(Continued)*

Employment: *(Continued)*

Do you receive any public assistance? **If Yes,** what is the name of the public assistance program? ☐ Yes ☐ No

Are you on any disability programs? **If Yes,** what is the name of the disability program? ☐ Yes ☐ No

Section 7: Contacts With The Courts And Other State Agencies

A. Criminal Court

Arrest Record:

Have you ever been arrested? **If Yes,** please state the date of arrest, charges and outcome *(disposition)* for all: ☐ Yes ☐ No

Are you currently on Probation or Parole? **If Yes,** please state the location and the name of your probation/parole officer: ☐ Yes ☐ No

Does anyone else currently living in your home or does your significant other have criminal arrests or convictions? **If Yes,** please state the date of arrest, charges and dispositions for all: ☐ Yes ☐ No

Arrest Record for the Other Parent:

Has the other parent ever been arrested? **If Yes,** please state the date of arrest, charges and outcome *(disposition)* for all: ☐ Yes ☐ No

Is the other parent currently on Probation or Parole? **If Yes,** please state the location and the name of the probation/parole officer: ☐ Yes ☐ No

Does anyone else currently living in the other parent's home or does the other parent's significant other have criminal arrests or convictions? **If Yes,** please state the date of arrest, charges and dispositions for all: ☐ Yes ☐ No

B. Domestic Violence

1. Has there ever been violence between you and the other parent? ☐ Yes ☐ No
2. Did the police intervene during any of these incidents? ☐ Yes ☐ No
3. If an arrest was made, was the case referred to Family Services? **If Yes,** please provide the number of referrals, the dates of referral, the court location and the outcome: ☐ Yes ☐ No
4. Are there currently or have there been Criminal Protective Orders or Civil Restraining Orders in effect? **If Yes,** please provide details: ☐ Yes ☐ No
5. Is there a current allegation that the other parent is behaving violently toward their present significant other? ☐ Yes ☐ No

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Section 7: Contacts With The Courts And Other State Agencies *(Continued)*

C. Department of Children And Families And The Juvenile Court

1. Has DCF ever received a referral involving you, the other parent and the children? **If Yes,** how many investigations were opened and which DCF office investigated? ☐ Yes ☐ No

2. What was the outcome of the investigation(s)?

☐ Allegations of abuse or neglect were substantiated
How many times? _____

☐ Allegations of abuse or neglect were not substantiated
How many times? _____

3. Has DCF ever received a referral involving your current partner/significant other? **If Yes,** how many investigations were opened, which DCF office investigated and what was the outcome? ☐ Yes ☐ No

4. Has a case involving you, the other parent or the children ever been brought to the Juvenile Court or the Probate Court? **If Yes,** please indicate the reason why the matter was referred to the Court and outcomes. ☐ Yes ☐ No

Section 8: Psychological, Psychiatric, Counseling, Alcohol And Drug Treatment History

A. Psychological And Psychiatric Treatment

1. Are you currently in counseling or therapy? **If Yes,** please state the therapist and/or agency that is providing this service, the telephone number and the complete mailing address: ☐ Yes ☐ No

2. Were you ever in counseling or therapy? **If Yes,** please list in chronological order (*by year)* the therapists, counselors, clergy and/or marital counselors that you have utilized for services: ☐ Yes ☐ No

Date	Name of Therapist/Agency	Complete Mailing Address	Telephone number
1)			
2)			
3)			

3. Have you ever been hospitalized for psychiatric treatment? **If Yes,** please list hospitals or clinics attended for these services and the corresponding dates of treatment: ☐ Yes ☐ No

Date	Hospital/Clinic	Complete Mailing Address	Telephone number
1)			
2)			
3)			

4. Have you or the other parent ever taken psychiatric medication? **If Yes,** please list the names of all medication and the name, telephone number and the complete mailing address of the physician who prescribed the medication: ☐ Yes ☐ No

5. Has the other parent ever been in counseling/therapy or hospitalized for psychiatric treatment? **If Yes,** please list the therapist, agency or hospital that provided the services and the dates of treatment: ☐ Yes ☐ No

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B. Alcohol And Substance Abuse

1. Are you currently in or have you received treatment for alcohol or substance abuse? ☐ Yes ☐ No
   Please check all applicable treatment:

☐ Counseling/Therapy ☐ Detox ☐ Rehab Inpatient ☐ Rehab Outpatient ☐ AA/NA

If a box was checked, please list, in chronological order, the therapist/agency/hospital utilized for treatment:

Date	Therapist/Hospital	Complete Mailing Address	Telephone number
1)			
2)			
3)			

2. Has the other parent ever received treatment for alcohol or substance abuse? **If Yes,** please list the therapist/agency/hospital utilized and the dates of treatment: ☐ Yes ☐ No

C. General Health

1. Are you or have you been under the care of a physician for a significant medical issue or condition? ☐ Yes ☐ No
   If Yes, please specify the treating physician, the complete mailing address, and telephone number of the doctor and briefly outline the reason for treatment:

2. Has the other parent ever been under the care of a physician for a significant medical issue or condition? ☐ Yes ☐ No
   If Yes, please list the condition, the treating physician and the dates of treatment:

Section 9: Family Relationships And Personal References

Please list three (3) personal references of people *(e.g., family members, friends)* who know you as a parent :

Name	Complete Mailing Address	Telephone number	Relationship To Self
1)			
2)			
3)			

List family members that have close relationships with your children.
1)
2)
3)
4)

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