

Parenting Coordination Assessment

Date: _____

How did you hear about Renewed Hope Parenting Coordination (PC) Services?

1. SELF

Name: _____

First

Middle

Last

Address: _____

City

State

Zip

Phone: _____ Email: _____

b. In the event the Parent Coordinator may need to contact you, please indicate your preferred method for receiving messages:

Phone call: yes _____ no _____

Leave message: yes _____ no _____

Phone text: yes _____ no _____

Email: yes _____ no _____

2. EMPLOYMENT

Occupation: _____

Supervisor: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____

3. REPRESENTATION

Please list any professional contacts that need to be advised of this parenting coordination process:

a. Attorney: Yes _____ No: _____

Name: _____

Phone: _____ Email: _____

b. Counselor/Therapist: Yes _____ No: _____

Name: _____

Phone: _____ Email: _____

c. Other Professionals (*i.e., caseworkers, police officers, coaches, teachers*): Yes _____ No _____

Name: _____

Phone: _____ Email: _____

d. Emergency Contact: (*optional*) Yes _____ No _____

Name: _____

Phone: _____ Email: _____

4. HISTORY

a. When did you marry or meet the other party? _____ When did you separate? _____

b. Have there been police reports of abuse/neglect? Yes _____ No _____

If yes, explain:

c. Is there a protection/restraining order against you? Yes _____ No _____

If yes, explain:

d. Do you have any concerns about family violence? Yes _____ No _____

If yes, explain:

e. Do you have any concerns about the safety of the child(ren)? Yes _____ No _____

If yes, explain:

f. Do you have any concerns about substance use (*drugs, alcohol, or prescription*) by the other Parent?

Yes _____ No _____ If yes, explain:

g. Are there any mental health issues impacting the other Parent or child(ren)? Yes _____ No _____

If yes, explain:

h. Do you or your child/ren have any health issues? Yes _____ No _____

If yes, explain:

i. When is the last time you and your child(ren) were together?

5. CHILDREN

a. Please list the children involved in this case below:

NAME	AGE	DOB	LIVING WITH

b. What school(s) do your child(ren) go to? Please list below:

SCHOOL	TEACHER	CONTACT INFO

c. Please indicate the child(ren)s primary care doctor:

Name: _____

Phone: _____ Email: _____

d. Has the child(ren) seen a counselor or therapist? Yes _____ No _____

Name: _____

Phone: _____ Email: _____

e. Please list any other children living in your home or involved in this case below:

NAME	AGE	DOB	RELATIONSHIP TO YOU

f. Please list other adults living in your home or involved in this case below:

NAME	AGE	DOB	RELATIONSHIP TO YOU

6. PARENTING

a. What are your biggest challenges as a parent?

b. What are your biggest challenges with the co-parent?

c. Is there any other information the PC should know about?

7. NEXT STEPS

Please provide three available dates and times for the joint session.

1. _____
2. _____
3. _____

Thank you, I'll be in touch soon!

RENEWED HOPE
Pamala Campbell, M.S.

PC Intake

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