rh
Renewed Hope
Practical approaches to life's unexpected challenges

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. Have there been police reports of abuse/neglect? Yes ________ No _________

If yes, explain: ____

____

b. Is there a protection/restraining order against you? Yes _________ No _________

If yes, explain: ____

____

c. Do you have any concerns about family violence? Yes _________ No _________

If yes, explain: ____

____

d. Do you have any concerns about the safety of the child(ren)?

If yes, explain: ____

____

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

If yes, explain: ____

____

f. Are there any mental health issues impacting the other Parent or child(ren)?

If yes, explain: ____

____

g. Do you or your child/ren have any health issues? Yes _________ No _________

If yes, explain: ____

h. 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. What are your parenting goals?

____

____

____

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

____

____

____

7. NEXT STEPS

I will review your assessment during the 30-minute individual session. Please provide three dates and times of availably for this session:

1. ______________________
2. ______________________
3. ______________________

Please provide three dates and times of availably for the joint 60-minute session. session:

1. ______________________
2. ______________________
3. ______________________

Thank you, I'll be in touch soon!

RENEWED HOPE
Pamala Campbell, M.S.
720-446-8877
renew4hope.com
renew4hope@gmail.com