The Counseling and Cooperative Parenting Center of Ohio, LLC
CCPC·OHIO
8559 S. Mason Montgomery Rd, Mason, OH 45040
P: 513-229-8980 F: 513-229-8935 ccpc-ohio.com

SUPERVISED VISITATION INTAKE & CONTACT INFORMATION FORM

Date: _____

First Name: _____ M.I.: _____

Last Name: _____

Date of Birth: _____

SEX: ☐ Male ☐ Female

Age: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____Work Phone _____Cell Phone _____

Emergency Contact Name/Number: _____

Your Attorney: _____ Phone#: _____

Attorney's firm:_____ Fax #:_____

Attorney's address_____

Attorney's e-mail_____

If divorced, date of divorce_____

Car make and model_____

License Plate (state and #)_____

By providing the above information you acknowledge that CCPC-Ohio may contact you through any of these methods.

Attorney for the Children (GAL): _____

Attorney's Phone#:_____Attorney's Fax#:_____

ADULT INFORMATION

Are you currently taking any physician-prescribed medications or regularly take any "over the counter" medication, including any prescriptions for anxiety, depression or other mental conditions? ☐ Yes ☐ No
If yes, please specify _____
_____
_____

In the past, have you taken medication for a mental health condition? ☐ Yes ☐ No
If yes, please describe:
_____
_____
_____

Have you ever experienced:
☐ Physical abuse ☐ Rape/sexual assault ☐ Emotional abuse
☐ Sexual abuse ☐ Domestic violence ☐ Other significant trauma

Have you ever engaged in:
☐ Physical abuse ☐ Rape/sexual assault ☐ Emotional abuse
☐ Sexual abuse ☐ Domestic violence ☐ Other significant trauma

Have you ever been alleged to have engaged in:
☐ Physical abuse ☐ Rape/sexual assault ☐ Emotional abuse
☐ Sexual abuse ☐ Domestic violence ☐ Other significant trauma

Please comment:
_____
_____
_____

EMPLOYMENT:
Are you currently employed outside the home? ☐ Yes ☐ No
If yes, what position do you hold and how long have you been at this particular job?
_____
_____
_____

LEGAL:
Have you been involved in any legal matters in the past/present? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____

Has there ever been a restraining order against either participating adult?
☐ Yes ☐ No

If yes, please specify: _____
_____
_____

CHILD INFORMATION (Regarding any children being supervised)

1) Child's Last Name _____

First Name_____

Date of Birth _____ Age _____

Gender ☐ Male ☐ Female

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? ☐ Yes ☐ No

If yes, please specify: _____
_____
_____

2) Child's Last Name _____

First Name_____

Date of Birth _____ Age _____

Gender ☐ Male ☐ Female

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? ☐ Yes ☐ No
If yes, please specify: _____
_____
_____

3) Child's Last Name _____

First Name_____

Date of Birth _____ Age _____

Gender ☐ Male ☐ Female

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? ☐ Yes ☐ No
If yes, please specify: _____
_____
_____

4) Child's Last Name _____

First Name_____

Date of Birth _____ Age _____

Gender ☐ Male ☐ Female

Current: Height _____ Weight _____

Does your child/adolescent have any drug/food allergies? ☐ Yes ☐ No
If yes, please specify: _____
_____
_____

HEALTH/MEDICAL HISTORY

Does your child have any significant health problems? ☐ Yes ☐ No
If yes, please specify: _____
_____
_____

Does your child have any significant behavioral problems? ☐ Yes ☐ No
If yes, please specify and include the name of any current treatment providers:
_____
_____
_____

Does your child take any medication? (Prescription and over-the-counter) ☐ Yes ☐ No
Please list:
Child's Name Medication Purpose
_____
_____
_____
_____

Please indicate if your child(ren) has experienced or witnessed the following traumas, using child's initials if more than one child is receiving services.

- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Rape/sexual assault
- ☐ Sexual abuse
- ☐ Other significant trauma
- ☐ None of the above

Comments:

_____

_____

Have any family members had problems with substance abuse (drugs, alcohol) or with mental or emotional problems? ☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Other Comments: _____

_____

_____

_____

_____

Thank you for providing this information.

_____ _____

Custodial Participant Date

_____ _____

Visiting Participant Date

_____ _____

Supervised Visitation Specialist Date