

**WESTMORELAND COUNTY DOMESTIC RELATIONS**

PHONE: 1-800-561-5022

FAX: (724) 830-3256

DATE: \_\_\_\_\_

FOR OFFICE USE ONLY

Plaintiff Name: \_\_\_\_\_  
Defendant Name: \_\_\_\_\_  
Docket Number: \_\_\_\_\_  
PACSES Case Number: \_\_\_\_\_  
Other State ID Number: \_\_\_\_\_

Intake Information Questionnaire/Data Sheet

PLAINTIFF'S/CARETAKER'S INFORMATION:

Relationship to Children: \_\_\_\_\_

Name (Last, First, Middle) \_\_\_\_\_

Maiden Name/Alias \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

SSN \_\_\_\_\_ D/O/B \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Physical Description: Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Eyes \_\_\_\_\_ Hair \_\_\_\_\_ Race \_\_\_\_\_

Plaintiff's Attorney \_\_\_\_\_

Plaintiff's Attorney Address \_\_\_\_\_

Employer Name \_\_\_\_\_ Net Pay \$ \_\_\_\_\_ per \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Medical Insurance Carrier Name \_\_\_\_\_ Policy # \_\_\_\_\_

Medical Insurance Carrier Address \_\_\_\_\_

\_\_\_\_\_ Carrier Phone (\_\_\_\_) \_\_\_\_\_

Marital Status with respect to Defendant \_\_\_ Divorced \_\_\_ Married \_\_\_ Separated \_\_\_ Single

Date Married \_\_\_\_/\_\_\_\_/\_\_\_\_ Separated \_\_\_\_/\_\_\_\_/\_\_\_\_ Divorced \_\_\_\_/\_\_\_\_/\_\_\_\_

Place of Marriage \_\_\_\_\_ Place of Divorce \_\_\_\_\_

Relative or Friend Name \_\_\_\_\_ Relationship \_\_\_\_\_

Relative or Friend Address \_\_\_\_\_

Relative or Friend Phone Number (\_\_\_\_) \_\_\_\_\_

Intake Information Questionnaire/Data Sheet

CHILDREN'S INFORMATION (Defendant's children only)

<u>NAME (Last, First, Middle)</u>	<u>SSN</u>	<u>DOB</u>	<u>AGE</u>	<u>SEX</u>	<u>PATERNITY ESTABLISHED</u>
_____	_____	_____	_____	_____	YES OR NO
_____	_____	_____	_____	_____	YES OR NO
_____	_____	_____	_____	_____	YES OR NO
_____	_____	_____	_____	_____	YES OR NO
_____	_____	_____	_____	_____	YES OR NO
_____	_____	_____	_____	_____	YES OR NO

DEFENDANT'S INFORMATION

Name (Last, First, Middle) \_\_\_\_\_

Maiden Name/Alias \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

SSN \_\_\_\_\_ D/O/B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Physical Description: Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Eyes \_\_\_\_\_ Hair \_\_\_\_\_ Race \_\_\_\_\_

Defendant's Attorney \_\_\_\_\_

Defendant's Attorney Address \_\_\_\_\_

Employer Name \_\_\_\_\_ Net Pay \$ \_\_\_\_\_ per \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Medical Insurance Carrier Name \_\_\_\_\_ Policy # \_\_\_\_\_

Medical Insurance Carrier Address \_\_\_\_\_

\_\_\_\_\_ Carrier Phone (\_\_\_\_) \_\_\_\_\_

