



**Blado | Kiger | Bolan, P.S.**

· ATTORNEYS AT LAW ·

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**FAMILY LAW INTAKE FORM**

TODAY'S DATE: \_\_\_\_\_

1. CLIENT INFORMATION		
A. NAME	B. DOB	C. BIRTHPLACE
D. DRIVER'S LICENSE NUMBER	E. EDUCATION & TRAINING	
F. MAILING ADDRESS	G. BILLING ADDRESS (if different)	
<i>Street</i>	<i>Street</i>	
<i>City State Zip</i>	<i>City State Zip</i>	
H. HOME PHONE	I. WORK PHONE	J. CELL PHONE
L. SOCIAL SECURITY NUMBER	M. E-MAIL ADDRESS	
<i>Have you consulted another attorney regarding this matter?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes, who?</i> <i>How did you learn of Blado Kiger Bolan, P.S.?</i>		
<input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet Search <input type="checkbox"/> Drove by	<input type="checkbox"/> Referred by: _____ <input type="checkbox"/> Friend - Name: _____ <input type="checkbox"/> Former client: _____	

**PLEASE NOTE!**

***Payment for your consultation, if applicable, is due before you meet with the attorney. For your convenience, we accept cash, personal check, VISA, MasterCard and Discover. Consultations that exceed the allotted time will be billed for the extra time at the attorney's normal hourly rate. Thank you for choosing our firm.***

2. SPOUSE/OPPOSING PARTY INFO:		
A. NAME	B. DOB	C. BIRTHPLACE
D. DRIVER'S LICENSE NUMBER	E. EDUCATION & TRAINING	
F. MAILING ADDRESS	G. ATTORNEY INFO (IF APPLICABLE)	
Street	Name	
City State Zip	Street	
	City State Zip	
H. HOME PHONE	I. WORK PHONE	J. CELL PHONE
L. SOCIAL SECURITY NUMBER		

3. MARRIAGE (IF APPLICABLE)	
A. PLACE OF MARRIAGE	B. DATE OF MARRIAGE
C. DATE OF SEPARATION	D. WIFE'S MAIDEN NAME
	RESTORED <input type="checkbox"/> YES <input type="checkbox"/> NO

4. LITIGATION			
<i>Has a domestic relations action been filed?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If so, please complete the following:</i>			
COURT NAME	CAUSE/CASE NO.	HEARING DATE (if any)	HEARING TIME (if any)

5. CHILDREN – OF THIS RELATIONSHIP (BORN OR ADOPTED):	
A. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:

**CHILDREN CONT.**

B. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:
C. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:
D. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:
E. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:
F. NAME	DOB:
	CURRENT AGE: _____
LIVING WITH:	SSN:
G. HEALTH PROBLEMS WITH CHILDREN	H. WIFE PREGNANT?
<i>LIST:</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO

## 6. PRIOR MARRIAGES OF CLIENT

<b>NAME OF FORMER SPOUSE</b>		<b>DATE OF DIVORCE</b>	
<b>CHILDREN BY PRIOR MARRIAGE</b>			
<b>NAME</b>	<b>AGE</b>	<b>SUPPORT PAID/REC'D AND AMOUNT</b>	<b>COUNTY, STATE</b>

<b>7. PRIOR MARRIAGES OF SPOUSE/PARTNER</b>			
<b>NAME OF FORMER SPOUSE</b>		<b>DATE OF DIVORCE</b>	
<b>CHILDREN BY PRIOR MARRIAGE</b>			
<b>NAME</b>	<b>AGE</b>	<b>SUPPORT PAID/REC'D AND AMOUNT</b>	<b>COUNTY, STATE</b>

<b>8. CLIENT EMPLOYMENT</b>	
<b>EMPLOYER</b>	<b>ADDRESS</b>
	<i>Street</i>
	<i>City State Zip</i>
<b>JOB TITLE</b>	<b>DATE OF HIRE</b>
<b>GROSS PAY (WEEK/BI-WEEKLY/BI-MONTHLY/MONTH)</b>	<b>NET PAY (WEEK/BI-WEEKLY/BI-MONTHLY/MONTH)</b>
<b>MEDICAL/DENTAL INSURANCE</b>	<b>WHO IS COVERED?</b>
<b>PENSION/RETIREMENT/PROFIT SHARING?</b>	<b>LIFE INSURANCE THROUGH EMPLOYER</b>
<b>UNEMPLOYED?</b>	<b>LAST WORKED:</b>

<b>9. SPOUSE/OPPOSING PARTY EMPLOYMENT</b>
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EMPLOYER	ADDRESS
	<i>Street:</i>  <i>City:</i> <i>State:</i> <i>Zip:</i>
JOB TITLE	DATE OF HIRE
GROSS PAY (WEEK/BI-WEEKLY/BI-MONTHLY/MONTH)	NET PAY (WEEK/BI-WEEKLY/BI-MONTHLY/MONTH)
MEDICAL/DENTAL INSURANCE	WHO IS COVERED?
PENSION/RETIREMENT/PROFIT SHARING?	LIFE INSURANCE THROUGH EMPLOYER
UNEMPLOYED?	LAST WORKED:

10. MEDICAL PROBLEMS	
CLIENT DISABILITY	SPOUSE DISABILITY

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**ATTORNEY'S NOTES:**

OFFICE USE ONLY		
Conflict Check Completed	Completed by (Initials)	Date
<input type="checkbox"/> Yes <input type="checkbox"/> No		