

ELDER LAW PLANNING QUESTIONNAIRE

Name of Client	
Name of Spouse	

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. If there is not enough space on the form for your answer to any question, attach an additional page to the form with a reference to the question you are answering.

Please bring the completed form with you to your appointment.

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SECTION 1. CONTACT PERSON

Client Communications	
All communications re: Elder Law Planning matter should be addressed to	<input type="checkbox"/> Spouse <input type="checkbox"/> Client <input type="checkbox"/> Spouse and Client <input type="checkbox"/> Include a Child/Relative/Other
If child or other, Name of Contact	
Gender of this other party	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work

SECTION 2. CLIENT DETAILS

2.1. CLIENT NAME, ADDRESS and DOMICILE

Name of Client	
Gender of Client	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name prefix	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Pastor <input type="checkbox"/> Prof. <input type="checkbox"/> Rev. <input type="checkbox"/> _____
Suffix	<input type="checkbox"/> Jr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> _____
Does the client have a nickname?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is the nickname?	
Does the client use an alias name?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is that alias?	
DOB	
Social Security Number	
Client is U.S. citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not a U.S. citizen, client is citizen of	
Contact Info and Address(es)	
Street Address 1	
Street Address 2	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work
Domicile Details	
State of legal domicile is different from client's "address" state, above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, state of Legal Residence	

2.2. Client Data

Client Data	
Has Client has been diagnosed with an illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Client a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is Client receiving Tricare?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3. SPOUSE DETAILS

3.1. Spouse/Partner Name, Address and Domicile

Name of Spouse/Partner	
Gender of Spouse/Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name prefix	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Pastor <input type="checkbox"/> Prof. <input type="checkbox"/> Rev. <input type="checkbox"/> _____
Suffix	<input type="checkbox"/> Jr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> _____
Does the Spouse/Partner have a nickname?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, nickname	
Spouse/Partner uses an alias?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, alias	
DOB	
Social Security Number	
Spouse/Partner is U.S. citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, Spouse/Partner is citizen of	
Contact Info And Address	
Include full primary address details for Spouse/Partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does Spouse/Partner have the same address as address as Client?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, Street Address 1	
Street Address 2	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work
Domicile Details	
State of legal domicile is different from Spouse/Partner's "address" state, above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, state of Domicile	

3.2. Spouse/Partner Data

SPOUSE/PARTNER DATA	
Spouse/Partner has been diagnosed with an illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Partner is a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is Spouse/Partner receiving Tricare?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4. MEDICAL DATA.

HEALTH INFORMATION for Institutionalized Spouse	
Health of Institutionalized Spouse	<input type="checkbox"/> is in reasonably good health <input type="checkbox"/> suffers from (specify diagnosis)
Specify Diagnosis	(check all that apply)
<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Aneurysm <input type="checkbox"/> Arterial Fibrillation <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Pain <input type="checkbox"/> Bedsores <input type="checkbox"/> Cancer <input type="checkbox"/> Carotid Arteries <input type="checkbox"/> Cellulitis <input type="checkbox"/> Cholesterol (high) <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Delirium <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Encephalitis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frailty resulting from age <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Attack (effects of previous) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hip Fracture (effects of) <input type="checkbox"/> Hypertension <input type="checkbox"/> Knee Surgery (effects of) <input type="checkbox"/> Krohn's Disease <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Quadruple Bypass <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Stroke (effects of prior) <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Institutionalized Spouse's Physician	
Do you know the name of Institutionalized Spouse's Physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name of Institutional Spouse's Physician	
Street Address	
Suite / Office # / Address 2	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work

HEALTH INFORMATION for Community Spouse	
Health of Community Spouse	<input type="checkbox"/> is in reasonably good health <input type="checkbox"/> suffers from (specify diagnosis)
Specify Diagnosis	(check all that apply)
<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Aneurysm <input type="checkbox"/> Arterial Fibrillation <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Pain <input type="checkbox"/> Bedsores <input type="checkbox"/> Cancer <input type="checkbox"/> Carotid Arteries <input type="checkbox"/> Cellulitis <input type="checkbox"/> Cholesterol (high) <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Delirium <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Encephalitis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frailty resulting from age <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Attack (effects of previous) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hip Fracture (effects of) <input type="checkbox"/> Hypertension <input type="checkbox"/> Knee Surgery (effects of) <input type="checkbox"/> Krohn's Disease <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Quadruple Bypass <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Stroke (effects of prior) <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Other _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Community Spouse's Physician	
Do you know the name of Community Spouse's Physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name of Community Spouse's Physician	
Street Address	
Suite / Office # / Address 2	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work

SECTION 5. INCOME & EXPENSES

Monthly Income for Institutionalized Spouse		Amount		
Net Social Security				
Medicare Part B Deduction (Select or enter a number)		<input type="checkbox"/> \$94.60	<input type="checkbox"/> \$134.90	<input type="checkbox"/> \$192.70
		<input type="checkbox"/> \$250.50	<input type="checkbox"/> \$308.30	<input type="checkbox"/> \$_____
Medicare Part D				
Pension/Retirement Benefits (Gross)				
Employment				
Disability				
Annuity				
Rental				
Other Income				
	Item	Amount		
1				
2				
3				
4				
Total Income				

5.1. Monthly Income For Community Spouse

Monthly Income for Community Spouse		Amount		
Net Social Security				
Medicare Part B Deduction (Select or enter a number)		<input type="checkbox"/> \$94.60	<input type="checkbox"/> \$134.90	<input type="checkbox"/> \$192.70
		<input type="checkbox"/> \$250.50	<input type="checkbox"/> \$308.30	<input type="checkbox"/> \$_____
Medicare Part D				
Pension/Retirement Benefits (Gross)				
Employment				
Disability				
Annuity				
Rental				
Other Income				
	Item	Amount		
1				
2				
3				
4				
Total Income				

5.2. Monthly Shelter Expenses For Community Spouse

Monthly Shelter Expenses for Community Spouse		Amount
Rent Payments (monthly)		
Mortgage Payments (monthly)		
Real Estate Taxes (monthly)		
Water		
Sewer		
Trash disposal fees		
Average Monthly Utilities Bill (Heat, Electric & Telephone) (1/12 of expenses for last 12 months)		
Homeowner's Insurance Premium		
Condominium fees		
Other Shelter Expenses		
	Item	Amount
1		
2		
3		
4		
Total Shelter Expenses		

5.3. Monthly Non-Shelter Expenses For Community Spouse

Monthly Non-Shelter Expenses for Community Spouse		
Food		
Medical		
Clothing		
Transportation		
Home Maintenance		
Life Insurance Premium		
Health Insurance Premium		
Cable TV		
Federal and State Income Taxes		
Other Non-Shelter Expenses		
	Item	Amount
1		
2		
3		
4		
Total Nonshelter Expenses		

5.4. Nursing Home Cost For Institutionalized Spouse

Estimated/Actual Cost of Nursing Home Care for Institutionalized Spouse		Amount
Facility Cost		
Prescription Cost		
Incontinent Cost		
Medical Insurance Cost		
Are there any other Costs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Nursing Home Costs		
	Item	Amount
1		
2		
3		
4		
5		
6		
Total Nursing Home Costs		

SECTION 6. ASSET INVENTORY AND DETAILS

6.1. Non-Countable Assets

Item	Client	Spouse	Joint	Liability
Home				
Automobile				
Personal Effects				
Community Spouse's Retirement Plan				
Pre-paid Funeral (in irrevocable Trust)				

6.2. Countable Assets

6.2.1. Checking

Item	Client	Spouse	Joint	Liability

6.2.2. Savings

Item	Client	Spouse	Joint	Liability

6.2.3. Money Market

Item	Client	Spouse	Joint	Liability

6.2.4. Savings Certificates

Item	Client	Spouse	Joint	Liability

6.2.5. Automobile

Item	Client	Spouse	Joint	Liability

6.2.6. Other Real Estate

Item	Client	Spouse	Joint	Liability

6.2.7. Brokerage/Cap Accts

Item	Client	Spouse	Joint	Liability

6.2.8. Mutual Funds

Item	Client	Spouse	Joint	Liability

6.2.9. Stocks

Item	Client	Spouse	Joint	Liability

6.2.10. Bonds

Item	Client	Spouse	Joint	Liability

6.2.11. Annuities

Item	Client	Spouse	Joint	Liability

6.2.12. Cash Value Life Insurance

Item	Client	Spouse	Joint	Liability

6.2.13. Traditional Ira

Item	Client	Spouse	Joint	Liability

6.2.14. Roth Ira

Item	Client	Spouse	Joint	Liability

6.2.15. Retirement Accounts

Item	Client	Spouse	Joint	Liability

6.2.16. Other Assets

Item	Client	Spouse	Joint	Liability

6.2.17. Total Countable Assets

	Client	Spouse	Joint	Liability

6.3. Residence Information

Residence	
Purchase Price	
Purchase Costs (title & escrow fees, real estate agent commissions, etc.)"	
Improvements	
Selling Costs (title & escrow fees, real estate agent commissions, etc.)"	
Accumulated Depreciation	
Cost Basis	
Amount of Unified Credit Available	
Ownership History	
Has client owned the property for 2 of the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has client occupied the property for 2 of the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6.4. Life Insurance

Life Insurance Policies	
--------------------------------	--

First Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

Second Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

Third Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

Fourth Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

SECTION 7. PRIOR TRANSACTIONS

7.1. Gifts to an Individual or to a Trust

Gifts to an Individual or to a Trust	
Have Institutionalized Spouse and Community Spouse or either of them made any gifts within last five years to an individual or to a trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", describe the gift(s) in the spaces provided	

First Gift	
Name of Recipient	
Date of Gift	
Amount	
Gift from	<input type="checkbox"/> IS <input type="checkbox"/> CS <input type="checkbox"/> Both

Second Gift	
Name of Recipient	
Date of Gift	
Amount	
Gift from	<input type="checkbox"/> IS <input type="checkbox"/> CS <input type="checkbox"/> Both

Third Gift	
Name of Recipient	
Date of Gift	
Amount	
Gift from	<input type="checkbox"/> IS <input type="checkbox"/> CS <input type="checkbox"/> Both

Fourth Gift	
Name of Recipient	
Date of Gift	
Amount	
Gift from	<input type="checkbox"/> IS <input type="checkbox"/> CS <input type="checkbox"/> Both

Fifth Gift	
Name of Recipient	
Date of Gift	
Amount	
Gift from	<input type="checkbox"/> IS <input type="checkbox"/> CS <input type="checkbox"/> Both

7.2. Federal Gift Tax Returns

Federal Gift Tax Returns	
Have Institutionalized Spouse and Community Spouse or either of them ever filed a Federal Gift Tax Return?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide copies of returns.	

7.3. Real Estate Transfers

Real Estate Transfers	
Have Institutionalized Spouse and Community Spouse or either of them sold or otherwise transferred any real property within the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how many sales/transfers?	

First Transfer	
Address of Property	
Cost Basis	
Sale Price	
Date of Sale	

Second Transfer	
Address of Property	
Cost Basis	
Sale Price	
Date of Sale	

SECTION 8. INTERESTED PARTIES

8.1. Children

Name of Child #1	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both Client and Spouse <input type="checkbox"/> Client Only <input type="checkbox"/> Spouse Only
Is Child a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's address:	
Telephone	
Child is (check all that apply)	<input type="checkbox"/> Disabled <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor health <input type="checkbox"/> Drug addiction or alcoholism <input type="checkbox"/> Spendthrift
Is child is receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #2	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both Client and Spouse <input type="checkbox"/> Client Only <input type="checkbox"/> Spouse Only
Is Child a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's address:	
Telephone	
Child is (check all that apply)	<input type="checkbox"/> Disabled <input type="checkbox"/> Blind

Child's problems (check all that apply)	<input type="checkbox"/> Poor health <input type="checkbox"/> Drug addiction or alcoholism <input type="checkbox"/> Spendthrift
Is child is receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #3	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both Client and Spouse <input type="checkbox"/> Client Only <input type="checkbox"/> Spouse Only
Is Child a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's address:	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild
Relation to Institutionalized Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild
Telephone	
Child is (check all that apply)	<input type="checkbox"/> Disabled <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor health <input type="checkbox"/> Drug addiction or alcoholism <input type="checkbox"/> Spendthrift
Is child is receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #4	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both Client and Spouse <input type="checkbox"/> Client Only <input type="checkbox"/> Spouse Only
Is Child a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Child's address:	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild
Relation to Institutionalized Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild
Telephone	
Child is (check all that apply)	<input type="checkbox"/> Disabled <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor health <input type="checkbox"/> Drug addiction or alcoholism <input type="checkbox"/> Spendthrift
Is child is receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

8.2. Other Interested Parties

First Party	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Telephone	

Second Party	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Telephone	

Third Party	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Telephone	

Fourth Party	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Telephone	

SECTION 9. OTHER ISSUES

Other Issues	
Are there any other legal issues that I should be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the issues below	
	Issue
	Importance
1	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
2	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
3	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
4	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
5	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry

SECTION 10. REFERRAL

Referral Details	
By whom were you referred to this office	
Name / Firm	
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Telephone	
Referrer is	<input type="checkbox"/> Attorney <input type="checkbox"/> Financial Planner <input type="checkbox"/> Previous Client of Law Firm <input type="checkbox"/> Doctor <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____

SECTION 11. CERTIFICATION

The undersigned hereby represents to Maureen P. Gluntz, Attorney at Law, that the information contained in this questionnaire is accurate and complete, and that the undersigned understands that the law firm will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

Name

Date

Name

Date