

Client Interview Sheet

A. Personal Information

Full Name _____

Have you ever been known by any other names? _____

If so what names? _____

Residence Address and Residence Telephone/Fax Number: _____

E-Mail Address _____

Addresses for Past Five Years: _____

Occupation and Employer: _____

Employment Contracts _____

Business Address and Telephone Number: _____

Have you even been in the military? _____

Veterans Administration Claim Number: _____

Military Service Number: _____

Any disability? _____

Have you ever been employed by a US or state government agency?

Dates, Agency and Civil Service Number, if applicable: _____

Date and Place of Birth and Citizenship _____

Social Security Number _____

Full Name of Spouse (Any Other Names) _____

Spouse's Date and Place of Birth and Citizenship _____

(If spouse is also a client, provide information about employment, military service, government service, e-mail address.)

Spouse's Social Security Number _____

Date and Place of Marriage _____

Children:

Name	Date and Place of Birth	Married? Children?	Address

Are all children born out of your present marriage? _____

If not, identify child and parent of each child: _____

Any stepchildren? _____

Any adopted children? _____

Any deceased children? _____

If so, did they leave children now living? _____

Any prior marriages (your or your spouse)? _____

Dates and Courts Issuing Divorce Decrees: _____

If you are a widow/er, date and place of spouse's death and spouse's social security number: _____

Do you have any ongoing obligations under any separation agreement that might affect your estate plan? _____

Are you making alimony and/or support payments in accordance with either a Court Order or separation agreement? (Provide a copy of Order or Agreement)

Do you have any pre-nuptial or post-nuptial agreement with your current spouse? (Provide a copy of Agreement) _____

Does any child or other family member have a physical or mental condition requiring special treatment? _____

Have you or your spouse ever made a Will? _____

Is it in existence now? _____

Locations of original: _____

Revoked? _____

How revoked? _____

Accountant (Name, Address and Telephone Number)

Insurance Agent (Name, Address, Telephone Number and Type of Insurance: Life, Automobile, Health, Homeowner) _____

Stockbroker (Name, Address, and Telephone Number)

Financial Planner (Name, Address and Telephone Number)

Safe Deposit Box(es) (Location, Box Number, Whether Single or Joint Name)

Physician (Name, Address and Telephone Number)

Internist: _____

Specialist (type): _____

B. Asset Information

In every case, indicate whether the asset is owned solely by the client or by the client with another. Show form of ownership if another has an interest (joint, in common, joint with right of survivorship (JWROS). If asset is payable or transferable at death to another, so indicate. Attach sheets if there is not enough room here.

It is important to identify accounts in foreign banks, as special reporting requirements pertain to these. These should be clearly set forth in items 3 and 4 below. Foreign Bank and Financial Account Reporting requirements implemented in furtherance of the Patriot Act may apply to such accounts.

1. Residence (Provide Copy of Deed) _____

If an apartment, is it a co-op or condo? _____

Owner(s): _____

Date of Purchase: _____

Purchase Price: _____

Improvements: _____

Approximate Fair Market Value Today: _____

Amount and Date of Last Tax Assessment: _____

Amount of Remaining Mortgage Loan(s): _____

Holder of Mortgage: _____

Amount of Mortgage Insurance and Designated Beneficiary:

2. Any other real estate? _____

Provide location and some information as for residence (above):

Are you aware of or do you suspect that nay of the real property you own has an environmental problem that could affect the sale or use of the property? _____

If so, what is the nature of the problem? _____

3. Checking/Money Market Accounts:

Name of Institution (Include Brand): _____

In Whose Name: _____

Approximate Average Balance: _____

Account Representative With Whom You Normally Deal:

4. Savings Accounts and Certificates of Deposit:

Name of Institution (Include Branch) _____

In Whose Name: _____

Account Numbers: _____

Present Balance: _____

Account Representative With Whom You Normally Deal:

5. Bonds (Location, Amounts and Owners)

Corporate: _____

US Government: _____

Municipal: _____

6. Stocks (Location, Amounts and Owners):

7. Mortgages Owned: _____

8. Other Debts Owed to You: _____

9. Other Investments (Including Contracts to Purchase):

10. Special or Unique Items of Personal Property (Including Jewelry, Heirlooms, Art Works, Collections, Automobiles and Antique Furniture):

11. Interests in any valuable copyrighted material (*e.g.* books, art, images, music, *etc.*) A limited right to terminate any copyright assignment in such works may exist. The right of termination would be exercised by the original copyright author, or his or her spouse or her, if the original author is deceased. Describe Works: _____

12. Businesses; Any Interest in: _____

PROPRIETORSHIP

Can it be bequeathed? _____

Can it be sold as a going concern? _____

Must it be liquidated upon your death? _____

What is the business worth without you operating it? _____

PARTNERSHIP or LIMITED LIABILITY COMPANY (LLC)

Provide balance sheets and profit and loss statements for last five years, if available: _____

Partnership or LLC Agreement – What does it provide and who are the other partners/members? _____

Amount of business life insurance on partners/members: _____

What is your interest worth? _____

Provide your most recent Form K-1 and copy of partnership agreement/LLC agreement.

CLOSELY HELD CORPORATION

Provide current balance sheet and profit and loss statement. _____

Value of your service to business: _____

Is there a stock redemption plan or buy and sell agreement?
(Provide Copy) _____

Amount of business life insurance on stockholders: _____

How many shares issued? (Number and Class) _____

How many shares do you hold? (Number and Class) _____

Who are other major shareholders? (Relationship to you, if any) _____

What is your interest worth? _____

Employment Benefits: (Provide copy of all beneficiary designations)
Identify account number(s) and provide estimate value. _____

Group Insurance: _____

Other Retirement-type accounts (Provide copy of all beneficiary designations)
Identify account number(s) and provide estimate of value.

Keogh Account(s): _____

Life Insurance: (State whether whole life, term, life, etc.)(Provide copy of all
beneficiary designations)

Company: _____

Hospital, Long Term Care and Disability Insurance (not need for preparation of
Will but as guideline for needs planning): _____

Any anticipated inheritances? _____

Any anticipated special obligations to family members?

Do you have any powers of appointment? (If yes, provide document creating the
same) _____

Are you a beneficiary, trustee, or grantor of a trust? (If yes, provide the document)

Debts – What is the nature and extent of your indebtedness, including whether or
not any of the debts are secured by property previously listed (including contingent
liabilities)?

Have you or your spouse made any gifts in excess of the annual exclusion (formerly \$3,000, then \$10,000, now indexed)? Were gift tax returns filed? (Provide a copy)

C. Plan

Please provide copies of existing estate planning documents, including current Will, living trust, living Will, advance medical directive/health care power of attorney, financial power of attorney, power of disposition over bodily remains or real estate power of attorney, in addition to other documents requested elsewhere.

How do you wish to dispose of your assets? _____

1. Taxes – Who should bear the transfer tax burden (if any) on assets passing under your Will? _____

○ Outside your Will? _____

2. Funeral – Any directions concerning the funeral (do you wish cremation)?

3. Debts – Should mortgage loans be paid off at your death from estate assets?

4. Bequests (Including Alternate Dispositions) – State to whom and where applicable amounts. _____

5. Personal Effects: _____

6. Charitable Bequests (Including Alternative Disposition)

7. Are remaining assets outright or in Trust? _____

○ To whom? _____

8. Provisions if Assets Become Distributable to a Young Person: Age for Distribution of the Underlying Property; Name of Fiduciary (Trustee or Custodian); Disposition if Beneficiary Dies Before Distribution.

9. Names and Addresses of:

- Beneficiaries:

10. Does the plan omit a close relative who under ordinary circumstances might expect to receive some benefit through your Will? _____

- If so, why? _____

11. Names and Addresses of:

- Trustees _____

- Guardians for Minor Children _____

Have I spoken to this person about this appointment? Yes No

D. Heirs at Law and Next of Kin
(Including Those of Whole and Half Blood)

Please list names, ages and addresses of your living heirs and next of kin and, if deceased, date and place of death.

Father: _____

Mother: _____

Brother(s)/Sister(s): _____

Nephew(s)/Niece(s) – Indicate Parentage: _____

Grandchild(ren) – Indicate Parentage: _____

Uncle(s)/Aunt(s) – Indicate If Siblings of Father or Mother: _____

Cousin(s) – Indicate Parentage: _____

E. Personal Representative of Your Estate
Primary Appointment

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Successor Appointment

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

F. Financial Power of Attorney
Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Successor Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Successor to the Successor Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Healthcare Directive

Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Successor Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

Successor to the Successor Attorney-In-Fact

Name: _____

Address: _____

Phone Number: _____

Have I spoken to this person about this appointment? Yes No

OPTIONAL: Information for anyone you would encourage your agent to consult with prior to making any decisions. This does not limit the scope of people your agent could consult, it only serves to point them in a certain direction.

NAME	PHONE NUMBER

If my doctors certify that my death from a terminal condition is imminent, even if life sustaining procedures are used:

(If you want to make your preference known please check one box)

	Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
	Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
	Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgement would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to

interact with others, and there is no reasonable expectation that I will ever regain consciousness:

(If you want to make your preference known please check one box)

	Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
	Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
	Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgement would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency.

(If you want to make your preference known please check one box)

	Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
	Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
	Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgement would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

(Please Check One)

	YES
	NO

CHECK ONE: Stated Preferences

	I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.
	I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

CHECK ONE: Upon my death I wish to donate my organs:

	Any needed organs, tissues, or eyes.
	Only the following organs, tissues or eyes:
	I do not wish to donate my organs.

CHECK ALL THAT APPLY: I authorize the use of my organs, tissues, or eyes:

	For transplantation.
	For therapy.
	For research.
	For medical education.
	For any purpose authorized by law.

After any organ donation do you wish for your body to be donated for use in a medical study program?

- If you wish to do this, most jurisdictions require you to pre-register prior to death as an anatomical donor to the jurisdiction's specific program.

(Please Check One)

	YES
	NO