CONFIDENTIAL CLIENT QUESTIONNAIRE FOR MARRIED PERSONS

I. Personal Information

Names As Shown On Current Photo ID **Dates of Birth** **Places of Birth**

Spouse 1 - First Middle Last

Spouse 2 - First Middle Last

Telephone

Spouse 1 – Home _____ Cell _____

Spouse 2 – Home _____ Cell _____

Mailing Address

Spouse 1 – Address & Email

Spouse 2 – Address & Email

Employers

Spouse 1: _____ _____
Name Address Job Title Telephone

Spouse 2 _____ _____
Name Address Job Title Telephone

Years of Residence in California

Spouse 1: _____ Spouse 2: _____

If less than 10 years, note prior residences:

_____

Prior Marriages (state dates of prior marriages)

Spouse 1: _____ Spouse 2: _____

Children (This Marriage – continue to back of page if not enough space)
Child #1

Name Address Birth Date Age

Telephone City, State, Zip

Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Child #2

Name | Address | Birth Date | Age

Telephone | City, State, Zip

Marital Status | Natural/Adopted | Name of Spouse | Any Children? (If so, list names)

Child #3

Name | Address | Birth Date | Age

Telephone | City, State, Zip

Marital Status | Natural/Adopted | Name of Spouse | Any Children? (If so, list names)

Children (Prior Marriages - continue to back of page if not enough space)

Child #1

Name | Address | Birth Date | Age

Telephone | City, State, Zip

Marital Status | Natural/Adopted | Name of Spouse | Any Children? (If so, list names) | Prior Marriage of Husband or Wife

Child #2

Name | Address | Birth Date | Age

Telephone | City, State, Zip

Marital Status | Natural/Adopted | Name of Spouse | Any Children? (If so, list names) | Prior Marriage of Husband or Wife

Children (Deceased - continue to back of page if not enough space)

Child #1

Name | Birth Date

Natural/Adopted | Name of Surviving Spouse, if any | Any Children? (If so, list names)

Spouse 1 Parents

Father

Deceased? ☐ Yes ☐ No

Name	Address	Birth Date	Age
Telephone	City, State, Zip		

Mother

Deceased? ☐ Yes ☐ No

Name	Address	Birth Date	Age
Telephone	City, State, Zip		

Spouse 2 Parents

Father

Deceased? ☐ Yes ☐ No

Name	Address	Birth Date	Age
Telephone	City, State, Zip		

Mother

Deceased? ☐ Yes ☐ No

Name	Address	Birth Date	Age
Telephone	City, State, Zip		

Brothers and Sisters

Spouse 1:

Name	Address	Birth Date	Age
Telephone	City, State, Zip		

Name	Address	Birth Date	Age

Telephone City, State, Zip

Spouse 2:

Name Address Birth Date Age

Telephone City, State, Zip

Name Address Birth Date Age

Telephone City, State, Zip

Is either Spouse a citizen of a foreign country? _____

If so, please state which spouse and the foreign country: _____

Does either Spouse:	**Yes**	**No**
Expect to receive gifts from parents or others?	☐	☐
Expect to inherit something from parents or others?	☐	☐
Currently own stock in an S corporation (a small business corporation that elected to have income taxed to its shareholders)?	☐	☐

Currently receive benefits from a qualified retirement plan?
If so, please state the name of each plan and the year of retirement:

Plan Name	**Year of Retirement**
_____	_____
_____	_____

	Yes	**No**
Expect to receive benefits from a qualified retirement plan?	☐	☐
Have beneficial interest in trusts?	☐	☐
Have interest in buy-sell agreement?	☐	☐
Have an interest in generation-skipping trust?	☐	☐
Have powers of appointment?	☐	☐
Is all your property Community Property?	☐	☐
Does Spouse 1 own Separate Property?	☐	☐
Does Spouse 2 own Separate Property?	☐	☐

Have either Spouse made gifts to their children or others in excess of $15,000 per person per year? ☐ ☐

Any marriage agreements prior to marriage? ☐ ☐

Any marriage agreements after marriage? ☐ ☐

Date and Place of Marriage: _____

Name and Address of Accountant: _____

Name and addresses of others who know about your financial affairs:

_____

Name Address

_____

Name Address

II. ASSETS & LIABILITIES

REAL ESTATE	Please use these descriptions in the TYPE column for your Real Estate Assets (continue to back of page if not enough space): Primary Residence Land Rental Property Commercial Property Second Residence Vacation Home	Owner choices: Co-Owned or Husband or Wife	
Type	Description	Owner	Asset Value
	Address:_____ City, State, Zip:_____		
	Address:_____ City, State, Zip:_____		
	Address:_____ City, State, Zip:_____		
	Address:_____ City, State, Zip:_____		

BANK ACCOUNTS	Please use these descriptions in the TYPE column for your Bank Account Assets (continue to back of page if not enough space): Checking CD Savings Money Market		

Type	Description	Owner	Asset Value
	Last 4 Digits of Account #_____ Bank Name:_____ Address:_____ City, State, Zip:_____		
	Last 4 Digits of Account #_____ Bank Name:_____ Address:_____ City, State, Zip:_____		
	Last 4 Digits of Account #_____ Bank Name:_____ Address:_____ City, State, Zip:_____		
	Last 4 Digits of Account #_____ Bank Name:_____ Address:_____ City, State, Zip:_____		
	Last 4 Digits of Account #_____ Bank Name:_____ Address:_____ City, State, Zip:_____		
INVESTMENT HELD AT FINANCIAL INSTITUTION	Please use these descriptions in the TYPE column for your Investment Assets (continue to back of page if not enough space): Mutual Fund Stock Brokerage		
Type	Description	Owner	Asset Value
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____		

	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____		

INVESTMENT HELD INDIVIDUALLY	Please use these descriptions in the TYPE column for your Investment Assets (continue to back of page if not enough space): Ltd. Partnership Bonds Common Stock Preferred Stock		
	# of Units or Shares:_____ Company Name:_____ Address:_____ City, State, Zip:_____		
	# of Units or Shares:_____ Company Name:_____ Address:_____ City, State, Zip:_____		

RETIREMENT EMPLOYER SPONSORED	Please use these descriptions in the TYPE column for your Retirement Assets (continue to back of page if not enough space): 401(k) 403(b) Section 457 Profit-Sharing Money Purchase Other		
Type	Description	Owner	Asset Value
	Last 4 Digits of Account #_____ Company Name:_____ Plan Administrator:_____ Address:_____ City, State, Zip:_____ Beneficiary:		
	Last 4 Digits of Account #_____ Company Name:_____ Plan Administrator:_____ Address:_____		

	City, State, Zip:_____ Beneficiary:		
	Last 4 Digits of Account #_____ Company Name:_____ Plan Administrator:_____ Address:_____ City, State, Zip:_____ Beneficiary:		

RETIREMENT INDIVIDUAL	Please use these descriptions in the TYPE column for your Retirement Assets (continue to back of page if not enough space): IRA SEP/IRA ROTH/IRA ROLLOVER/IRA Other		
Type	Description	Owner	Asset Value
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____ Beneficiary:		
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____ Beneficiary:		
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____ Beneficiary:		
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____ Beneficiary:		

BUSINESS	Please use these descriptions in the TYPE column for your Business Assets (continue to back of page if not enough space): General Partnership C Corporation Sole Proprietorship Ltd. Partnership (Bus.) S Corporation LLC		
Type	Description	Owner	Asset Value
	Company Name:_____ Address:_____ City, State, Zip:_____		

LIFE INSURANCE & ANNUITIES	Please use these descriptions in the TYPE column for your Life Insurance & Annuities (continue to back of page if not enough space): Term Whole Life/Universal Life Other		
Type	Description	Measuring Life	Value
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ City, State, Zip:_____ Beneficiary:		

NOTES & ACCOUNTS RECEIVABLE	Please describe all items over $100 due you (continue to back of page if not enough space):		
Date	Payor	Payee	Amount

PERSONAL PROPERTY (continue to back of page if not enough space):	**Present Value**
Home Furnishings	
Automobiles	
Jewels & Furs	
Safe Deposit Box	
Other (collections, art, etc.)	

LIABILITIES	Please use these descriptions in the TYPE column for your Liability Assets (continue to back of page if not enough space): Mortgage Other Loans Personal Loan		
Type	Description	Owner	Debt Value

Interest in Other Trusts:
Briefly describe name of trust, names of beneficiaries, your interest in the trust, and the approximate present net worth.

III. DISTRIBUTION & DESIGNATIONS

WHO WILL INHERIT YOUR ESTATE: (please include full name, address & phone – continue on to the back of the page if not enough space)

TRUSTEE(S):

Who will be your trustee(s)? (please include full name, address & phone)

Who will be your back-up/successor trustee(s)? (please include full name, address & phone)

EXECUTOR(S):

Spouse 1 - Who will be your executor(s)? (please include full name, address & phone)

Spouse 1 - Who will be your back-up/successor executor(s)? (please include full name, address & phone)

Spouse 2 - Who will be your executor(s)? (please include full name, address & phone)

Spouse 2 - Who will be your back-up/successor executor(s)? (please include full name, address & phone)

GUARDIAN(S):

Who will be the guardian(s) for your minor child or children? (please include name, address & phone)

Will they be the guardian of the person and the assets for the child or just the guardian of the child?

DURABLE POWER OF ATTORNEY:

Spouse 1 - Who will be your Attorney In Fact to make financial decisions for you if you are unable or incapacitated? (please include full name, address & phone)

Spouse 1 - Who will be your back-up/successor Attorney In Fact? (please include full name, address & phone)

Spouse 2 - Who will be your Attorney In Fact to make financial decisions for you if you are unable or incapacitated? (please include full name, address & phone)

_____

Spouse 2 - Who will be your back-up/successor Attorney In Fact? (please include full name, address & phone)

_____

ADVANCED HEALTH CARE DIRECTIVE:**

Spouse 1 - Who will be your Agent to make health care decisions for you if you are unable or incapacitated? (please include full name, address & phone)

_____

Spouse 1 - Who will be your back-up/successor Agent? (please include full name, address & phone)

_____

Spouse 2 - Who will be your Agent to make health care decisions for you if you are unable or incapacitated? (please include full name, address & phone)

_____

Spouse 2 - Who will be your back-up/successor Agent? (please include full name, address & phone)

_____

DOCUMENTS DESIRED BY ATTORNEY:

1. Copies of present Trusts and/or Wills, if any;
2. Copies of real property deeds, if any;
3. Copies of beneficiary designations for each of the following non-trust assets (including a copy of each written spousal consent to the beneficiary designation):
    a. Life insurance policies (including annuities);
    b. Employer Sponsored Retirement Plans; and
    c. Individual Retirement Accounts (IRAs, Roth IRAs, SEP-IRAs)

OPTIONS FOR ADVANCED HEALTH CARE DIRECTIVE

	Spouse 1:	Spouse 2:
Agent for AHCD	Name: Address: Telephone:	Name: Address: Telephone:
Successor Agent for AHCD	Name: Address: Telephone:	Name: Address: Telephone:

Autopsy (Check one)	❑ My agent may authorize an autopsy if she believes it necessary or helpful to an understanding of the circumstances surrounding my death. ❑ I recognize that an autopsy may sometimes be required by law, but when an autopsy is not required by law, I do NOT want my agent to authorize an autopsy.	❑ My agent may authorize an autopsy if she believes it necessary or helpful to an understanding of the circumstances surrounding my death. ❑ I recognize that an autopsy may sometimes be required by law, but when an autopsy is not required by law, I do NOT want my agent to authorize an autopsy.
Organ Donation (Check one)	❑ My agent may authorize donation. ❑ My agent may authorize donation of my organs with the following restrictions: _____ ❑ My agent may NOT donate my organs.	❑ My agent may authorize donation. ❑ My agent may authorize donation of my organs with the following restrictions: _____ ❑ My agent may NOT donate my organs.
Funeral and Burial Instructions (Check one)	❑ My agent may authorize the disposition of my remains according to what the agent knows to be my preference. ❑ My agent may authorize the disposition of my remains as noted on the back of this page. ❑ I have prepaid burial and funeral plans in place with the following entity: _____	❑ My agent may authorize the disposition of my remains according to what the agent knows to be my preference. ❑ My agent may authorize the disposition of my remains as noted on the back of this page. ❑ I have prepaid burial and funeral plans in place with the following entity: _____
End of Life Decisions (Check one)	❑ I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3)under any other circumstances in which the burdens of treatment outweigh the expected benefits. By an irreversible coma, I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. At the same time that I am signing this advance health care directive, I	❑ I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3)under any other circumstances in which the burdens of treatment outweigh the expected benefits. By an irreversible coma, I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. At the same time that I am signing this advance health care directive, I

	am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.	am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma," I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.	❑ I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma," I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable and irreversible condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and for which the application of life-sustaining procedures serves only to postpone the moment of my death, and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.	❑ If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable and irreversible condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and for which the application of life-sustaining procedures serves only to postpone the moment of my death, and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted healthcare standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.	❑ I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted healthcare standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.