

Client Information Workbook

Revised August, 2006

I. PERSONAL DATA

Today's Date: _____

Name: _____ DOB: ____ / ____ / ____ SS#: _____

Address: _____ Day Phone: _____ Eve. Phone: _____

_____ County of Residence: _____

Employer: _____ Retirement Date: _____ Veteran: Yes ___ No ___

Spouse: _____ DOB: ____ / ____ / ____ SS#: _____

Employer: _____ Retirement Date: _____ Veteran: Yes ___ No ___

II. FAMILY

Date of Marriage: _____

Please list all children below. (Use back of page if extra space is needed.)

First Name MI Last Name Address (street, town, state and zip) Phone

Spouse's Name Names and ages of Grandchildren

First Name MI Last Name Address (street, town, state and zip) Phone

Spouse's Name Names and ages of Grandchildren

First Name MI Last Name Address (street, town, state and zip) Phone

Spouse's Name Names and ages of Grandchildren

First Name MI Last Name Address (street, town, state and zip) Phone

Spouse's Name Names and ages of Grandchildren

Have you or your spouse been married before? yes _____ no _____

If yes, do you or your spouse have any children from this previous marriage? yes _____ no _____

Do you or your spouse have children who have died leaving children? yes _____ no _____

Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property? yes _____ no _____

Do you and your spouse have a pre-nuptial or post-nuptial agreement? yes _____ no _____

Is anyone in your family disabled? yes _____ no _____

If yes, please explain: _____

III. HEALTH INFORMATION

WIFE:

Doctor: _____

Name

Address

1) What medical or health problems do you currently have?

2) What medical problems have you had in the past?

3) Does your family have a history of health problems (for example, heart disease, cancer, Alzheimer's,...)

4) For the *Wife*, tell us about your parents:

Mother

Father

Age of Death: _____

Cause of Death: _____

HUSBAND:

Doctor: _____

Name

Address

1) What medical or health problems do you currently have?

2) What medical problems have you had in the past?

IV. FUNCTIONAL LIMITATIONS AND SUPPORT

The term “activities of daily living” refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities, the more likely are they to be admitted to a nursing home or other living arrangement; to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Please place an X in the box that most applies for each activity.

Wife's Activities of Daily Living

Activity	Need No Help	Need Some Help	Unable To Do At All
Bathing			
Dressing			
Transferring from bed to chair____			
Walking			
Feeding self__			
Using the toilet			
Grooming			

Wife's Instrumental Activities of Daily Living

Activity	Need No Help	Need Some Help	Unable To Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

<i>Wife</i>	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

Please list the names of all persons who provide assistance or caregiving for you:

Please place an X in the box that most applies for each activity.

Husband's Activities of Daily Living

Activity	Need No Help	Need Some Help	Unable To Do At All
Bathing			
Dressing			
Transferring from bed to chair____			
Walking			
Feeding self__			
Using the toilet			
Grooming			

Husband's Instrumental Activities of Daily Living

Activity	Need No Help	Need Some Help	Unable To Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

<i>Husband</i>	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

Please list the names of all persons who provide assistance or caregiving for you:

V. HEALTH INSURANCE

	<u>Husband</u>	<u>Wife</u>
Medicare	_____	_____
	Number	Number
Insurance from Employer	_____	_____
Medicare Supplement	_____	_____
Long-Term Care Insurance	_____	_____
Prescription Drug Plan	_____	_____

VI. FINANCIAL

Bank accounts, CDs, Brokerage Accounts, Stocks, Corporate or U.S. Bonds, other

Description & Location of Property	Value	Account No.	In Whose Name?
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____

TOTAL: \$ _____

Other Property with Designated Beneficiaries:
 Do you have IRAs, vested pension plan, annuities, or other assets that would pass on your death to a particular beneficiary that you have designated?

Description	Value	Designated Beneficiary
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Have you or your spouse made any transfers or gifts of \$500.00 or more during the past five years?
 yes _____ no _____

Real Estate:

Description of Property	Purchase Date	Purchase Price	Value	In Whose Name?
_____	_____	\$ _____	_____	_____
_____	_____	\$ _____	_____	_____

Do you or your spouse have an interest in any business? yes _____ no _____

Monthly Income:

	<u>Husband</u>	<u>Wife</u>	<u>Joint</u>
Social Security	\$ _____	\$ _____	\$ _____
Employment	\$ _____	\$ _____	\$ _____
Pension from _____	\$ _____	\$ _____	\$ _____
IRAs, Annuities, etc. _____	\$ _____	\$ _____	\$ _____
Rents _____	\$ _____	\$ _____	\$ _____
Business Interest _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____
TOTALS:	\$ _____	\$ _____	\$ _____

VIII. LEGAL

	Date Made	Location of Original
Last Will and Testament	_____	_____
Durable Power of Attorney	_____	_____
Living Will/Health Care Proxy	_____	_____
Living Trust	_____	_____

I am the legally appointed guardian of: _____

I have been appointed under a power of attorney from: _____

I am serving as executor or administrator of an estate: _____

I am involved in a lawsuit: _____

I have lived in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington)

Other legal concerns: _____

PLEASE REMOVE THIS PAGE (DOCUMENT CHECKLIST) TO BRING WITH YOU ALONG WITH COPIES OF THE DOCUMENTS.

Should you have any questions or need help in completing this form, please call our office at 570-746-3844.

Document Checklist

Please bring copies of the following documents with you to your meeting with Attorney Wizelman:

- _____ 1. Will, codicil, trust agreements
- _____ 2. Real estate deeds, appraisals (if any)
- _____ 3. Admission agreements to hospitals and health facilities
- _____ 4. Divorce decrees, prenuptial agreements, adoption papers
- _____ 5. Guardianship documents
- _____ 6. Living will, health care declaration or power of attorney, durable powers of attorney
- _____ 7. Life Insurance policies and annuities.
- _____ 8. A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries or your estate, helpers, and advisors