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CLIENT QUESTIONNAIRE

This form is extremely important. Please answer all questions that are pertinent to your situation. Your accuracy in responding will help us to best represent you. Upon completion, please bring this information with you to your appointment. **Please list names as they would appear on legal documents.**

HUSBAND

WIFE

GENERAL INFORMATION

_____	Full Name	_____
_____	Also Known As	_____
_____	Home Address	_____
_____	City, State, Zip	_____
_____	Home Phone	_____
_____	Cell Phone	_____
_____	Birth Date	_____
_____	Social Security #	_____
Yes _____ No _____	U.S. Citizen?	Yes _____ No _____
_____	Veteran?	_____
_____	Marriage Date	_____

Have you entered into any prenuptial, postnuptial or property settlement agreement with your spouse regarding division of property upon divorce or death?

Yes _____ No _____

If Yes, Please attach a copy of your agreement.

Has your marriage terminated? _____ If so, How? _____
PRIOR MARRIAGES (If Applicable)

HUSBAND

WIFE

_____ **Name of Former Spouse** _____

_____ **Date of Termination** _____

_____ **Reason for Termination** _____
Death, Divorce, Annulment

If Divorced, please indicate whether you entered into any property settlement agreements with your former spouse. Please provide a copy of the agreement.

FULL NAMES OF CHILDREN

1. Name _____ **Age** _____ **Sex** _____ **Marital Status** _____

Address _____

Phone: Cell _____ **Home** _____ **Spouse=s Name** _____

2. Name _____ **Age** _____ **Sex** _____ **Marital Status** _____

Address _____

Phone: Cell _____ **Home** _____ **Spouse=s Name** _____

3. Name _____ **Age** _____ **Sex** _____ **Marital Status** _____

Address _____

Phone: Cell _____ **Home** _____ **Spouse=s Name** _____

4. Name _____ **Age** _____ **Sex** _____ **Marital Status** _____

Address _____

Phone: Cell _____ **Home** _____ **Spouse=s Name** _____

5. Name _____ Age _____ Sex _____ Marital Status _____

Address _____

Phone: Cell _____ Home _____ Spouse=s Name _____

6. Name _____ Age _____ Sex _____ Marital Status _____

Address _____

Phone: Cell _____ Home _____ Spouse=s Name _____

7. Name _____ Age _____ Sex _____ Marital Status _____

Address _____

Phone: Cell _____ Home _____ Spouse=s Name _____

Additional Children? Yes No If yes, please list them on the back of this page.

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FULL NAMES OF GRAND CHILDREN

Name	Age	Marital Status	Parent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DISPOSITIVE INTENTIONS (FOR YOUR WILL)

1. CHILDREN

If you have children, do you wish to treat all of your children equally? ___ Yes ___ No

If not, why not? _____

After your death, at what age do you want distribution to your Children? _____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

2. GRANDCHILDREN

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? ___ Yes ___ No

Do you wish to treat all of your grandchildren equally? ___ Yes ___ No
If not, why Not? _____

How much do you want to leave your grandchildren? _____

At what age do you want distributions to your grandchildren? _____
(e.g., a typical plan provides for 1/3 at age 25, 1/3 at age 30, 1/3 at age 35 or immediate)

3. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? ___ Yes ___ No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

4. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren or a charity? ____ Yes ____ No

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

5. EXECUTOR

Whom do you wish to serve as your **Executor**?

First Choice _____

Second Choice _____

Third Choice _____

6. TRUSTEE

Whom do you want to serve as your **Trustee**?

First Choice _____

Second Choice _____

Third Choice _____

7. GUARDIAN

If you have **minor** or **disabled** child/children, whom do you want to act as **Guardian**?

First Choice _____

Second Choice _____

Third Choice _____

LIVING WILL

Do you want your Living Will to provide for withdrawal of artificial food and fluid? ___ Yes ___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Do you want your Health Care Agent to consult with any other person prior to acting? ___ Yes ___ No

If yes, with whom? _____

Name of Proposed **Health Care Agent** _____

Street Address _____

City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Name of Proposed **First Alternate Health Care Agent** _____

Street _____

City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

Name of Proposed **Second Alternate Health Care Agent** _____

Street _____

City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

What is the name and address of your **Primary Care Physician**?

Full Name of Physician _____

Street Address _____

City _____ State _____ Zip _____

Phone: Cell _____ Home _____ Work _____

POWER OF ATTORNEY

Name of **Proposed Financial Agent** _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed **First Alternate Financial Agent** _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed **Second Alternate Financial Agent** _____

Street Address _____

City _____ State _____ Zip _____

THIS SECTION INTENTIONALLY LEFT BLANK

MONTHLY INCOME

HUSBAND

WIFE

_____	Pension	_____
_____	Social Security	_____
_____	Veteran=s Disability	_____
_____	IRA/Annuity	_____
_____	Rental	_____
_____	Business Interest	_____
_____	Employment	_____
_____	Other	_____

MONTHLY EXPENSES

_____	Food	_____
_____	Rent/Mortgage	_____
_____	Electric/Gas	_____
_____	Phone	_____
_____	Water/Sewer	_____
_____	Home Aide	_____
_____	Other	_____

STATE PHARMACEUTICAL PLAN

Are you or your spouse receiving PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or any other State pharmaceutical plan?

Yes_____ No _____

Yes_____ No _____

ASSETS- Please Fill in Amounts and Values

REAL ESTATE PROPERTY

Please state the value of your property, and the amount of the mortgage if any against the property.

	\$Husband	\$Wife	\$Joint	\$Amount Owed
Residence				
Other*				
Other**				

* Please state the location of the other property _____

** Please state the location of the other property _____

PERSONAL PROPERTY

Please state the value of your following:

	\$Husband	\$Wife	\$Joint
Furnishings			
Jewelry & Furs			
Art			
Collections (stamp etc.)			
Autos and Boats			
Other			

BANK ACCOUNTS

Please list the name of your financial institution, the owner of the account, the account number and the value.

SAVINGS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CHECKING

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CD=s

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MONEY MARKET

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STOCKS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

U.S. SAVINGS BONDS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TREASURY NOTES, BONDS, BILLS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IRA=s (Please indicate if Qualified or Unqualified)

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

401(k)=s

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____

TIAA/CREF

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SAVINGS PLANS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEFERRED COMP

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GROUP INSURANCE

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ANNUITIES (Please indicate if qualified or unqualified)

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIFE INSURANCE (please indicate if term or whole life)

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there any outstanding loans against the above policies? Yes _____ No _____

If Yes, Please indicate the amount of the loan and the policy _____

OTHER ASSETS

Financial Institution	Owner	Account Number	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EXPECTED INHERITANCES

HUSBAND

WIFE

Do you anticipate receiving gifts or inheritances?

Yes _____ No _____

Yes _____ No _____

If known will the gift be given outright or in trust?

Outright _____ Trust _____

Outright _____ Trust _____

MISCELLANEOUS INFORMATION

Have you filed gift tax returns?

Yes _____ No _____

Yes _____ No _____

Do you have a prepaid funeral arrangement?

Yes _____ No _____

Yes _____ No _____

Do you have prepaid cemetery plots?

Yes _____ No _____

Yes _____ No _____

MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain _____

What is the location of your important papers? _____

Do you have a Safe Deposit Box? Yes No

If yes, please indicate the name and address of the location _____

Have you ever made gifts to any one person in excess of \$10,000 in any one calendar year?

Yes No

Have you ever filed a Federal Gift Tax Return? Yes No

GIFTS

Please list gifts made in excess of \$1,000.00 in any one month within the past 36 months?

<u>Date</u>	<u>Recipient</u>	<u>Amount</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONTACTS

Please provide the names and addresses of the following professionals who assist you:

ACCOUNTANT

Name _____

Address: _____

Tel. No.: _____

INSURANCE AGENT

Name: _____

Address: _____

Tel. No.: _____

STOCK BROKER

Name: _____

Address: _____

Tel. No.: _____

DOCTOR

Name: _____

Address: _____

Tel. No.: _____

The undersigned hereby represents that the information contained in this Client Questionnaire is accurate and complete. The undersigned understands that Pisciotta & Menasha, LLC will rely upon the information provided herein. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by Pisciotta & Menasha, LLC may not be appropriate.

Signature of Client or Client Representative

Date: _____

Signature of Client or Client Representative

Date: _____

For Office Use Only

Client Referred By: _____

File Type: _____

Fees Quoted: \$ _____ Initial Consultation

\$ _____

\$ _____

\$ _____