Pre-Planning Initial Consultation Intake Form

CARNEY ELDER LAW

Carney Elder Law
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Today's Date: _____

Name: _____ Spouse, if married: _____
Date of Birth: _____ Spouse's DOB: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Email: _____

1. **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced
2. **Children's Names/Age** (if any):

Name	DOB

Pre-Screening Health Statement - Part A

	Client	Spouse (if applicable)
1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?	☐ Yes ☐ No	☐ Yes ☐ No
4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?	☐ Yes ☐ No	☐ Yes ☐ No

Client and Spouse Pre-Screening Health Statement - Part B

Client: _____ **Height:** _____ **Weight:** _____

1. In the past 5 years, is there a history of:

☐ Diabetes ☐ Leukemia ☐ Heart Disease ☐ Heart Attack ☐ Stroke
☐ Depression ☐ Congestive Heart Failure ☐ Cardiomyopathy
☐ Uncontrolled High Blood Pressure ☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Cancer ☐ Organ Failure/Disease ☐ Chronic Obstructive Lung Disease (COLD)
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Alcohol/Drug Abuse

Other: _____

Medication	Dose	Frequency	Reason

2. Comments: _____

Spouse: _____ **Height:** _____ **Weight:** _____

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☐ Depression ☐ Congestive Heart Failure ☐ Cardiomyopathy
☐ Uncontrolled High Blood Pressure ☐ Amyotrophic Lateral Sclerosis (ALS)
☐ Cancer ☐ Organ Failure/Disease ☐ Chronic Obstructive Lung Disease (COLD)
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Alcohol/Drug Abuse

Other: _____

Medication	Dose	Frequency	Reason

2. Comments: _____

Financial Information

1. **Own Home?** ☐ Yes ☐ No **Value $** _____
2. **Outstanding Mortgage $** _____
3. **Own other property/real estate?** ☐ Yes ☐ No **Description:** _____
   Value $ _____ **Mortgage $** _____

5. **Monthly Income:**

Type	Client Income	Spouse Income
Social Security		
Gross Wages		
Pensions		
Spousal Pension Continuation Benefit		
Military Retirement		
Interest/Dividends		
Investment Property		
Income from IRA's		
Other		
TOTAL		

Do you rely on IRA Income for living expenses? ☐ Yes ☐ No

6. **Assets:**

Checking/Savings Account	Owner of Account	Value of Account
TOTAL		

CD's/Money Markets	Owner of Account	Value of Account
TOTAL		

Stocks/Bonds	Owner	Value of Account	Cost Basis
TOTAL			

Annuities	Owner	Value	Cost Basis	Surrender Value
TOTAL				

Mutual Funds	Owner	Value of Account	Cost Basis
TOTAL			

IRA's	Owner	Investment Type	Value of Account	Surrender Value
TOTAL				

401k	Owner	Investment Type	Value of Account	Surrender Value
TOTAL				

Is owner of 401k account still working? ☐ Yes ☐ No

Other/Cash Value Life Ins.	Owner	Death Benefit	Cash Value	Cash Surrender Value
TOTAL				

Clients Goals and Objectives

1. **Is there a Long-Term Care Insurance Plan in place?** ☐ Yes ☐ No
   Total Benefit Amount $ _____ **Daily Benefit Amount $** _____ **Premium $** _____
   How many rate increases have you experienced? _____
2. **If you get sick and need LTC, where would you want to receive care?**
   ☐ At home ☐ Assisted Living ☐ Nursing Home
3. **Assuming you need LTC, which asset would you liquidate first to pay for care?**
   ☐ Checking/Savings ☐ IRA ☐ Annuities ☐ Stocks/Bonds/Mutual Funds

Please tell us what you are hoping to accomplish for your client with this plan? _____

Are there any special circumstances we should be aware of as we design this plan, e.g. client likes, dislikes, or any factors we should be aware of that will make this plan the perfect for for your clients? _____

Follow up meeting scheduled: Date _____ Time _____

Do you intend this meeting to be: ☐ In Person ☐ GoToMeeting ☐ Conference Call

Who is the primary contact in your law office in case we have any questions about this fact finder?

_____

What is the best way to reach him/her?

☐ Phone: _____

☐ Email: _____

☐ Cell Phone: _____

Attorney Signature: _____