Please read these instructions and the cover letter carefully

Welcome to the Law Offices of Alice Reiter Feld.

We are looking forward to working with you.

In order for us to adequately represent you and determine your needs, it is very important that the attached intake **be completely filled out.** This is *in addition* to bringing statements, deeds, lists, spreadsheets, etc. We need this done prior to our appointment. Although we welcome and encourage you to bring all backup documents to the meeting, we request that our intake be completed in the format we have provided.

(However, you are welcome to attach a medication list instead of completing the medication section.)

If you need ***any*** help completing this intake please do not hesitate to contact us and we will be happy to help in any way we can.

Thank you in advance for your kind cooperation.

Initial Consultation Intake Form

Referred by: _____ **Today's Date: _____**

Name:_____ S.S. # _____ Date of Birth: _____

Spouse, if married: _____ S.S. # _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Marriage (if applicable): _____

Email: _____

Marital Status: ( ) Married ( ) Single ( ) Widowed ( ) Divorced

Number of Children: _____ Grandchildren: _____ Great Grandchildren: _____

INFORMATION REGARDING CHILDREN AND BENEFICIARIES

NAME	ADDRESS	PHONE NUMBER	EMAIL ADDRESS	RELATIONSHIP Who are they children of? (Husband, Wife, Both)	DATE OF BIRTH

1. May we contact your children? If so, which ones? _____
_____

2. Are any of the family members disabled? Yes ____ No ____ If yes, please indicate which one(s) and the extent of the disability. _____

3. Who is your Primary Care Physician? : _____ Phone #: _____

4. Do you have pre-paid funeral and cemetery arrangements? : Yes ____ No ____ If no, would you like information about this? Yes ____ No ____

5. Who is your financial advisor/investment counselor? Name: _____ Phone: _____

6. Who is your Accountant? : Name: _____ Phone: _____

7. May we have your consent to contact these allied professional as needed? Yes ____ No ____

8. Is there a Long-Term Care Insurance Plan in place? ( ) Yes ( ) No
If yes, is it a Partnership Plan? ( ) Yes ( ) No
If so, name of Insurance Company: _____
Daily/Monthly Benefit $ _____ Benefit Period: _____

9. Is/was the client a war veteran? ( ) Yes ( ) No Is/was spouse a war veteran? ( ) Yes ( ) No
Length of service: _____ What war? _____
Did they serve at least one day of active duty during wartime? ( ) Yes ( ) No

10. Is there a Durable Power of Attorney in place? ( ) Yes ( ) No
If so, who is listed as the POA? _____
_____

11. Is there a Will in place? ( ) Yes ( ) No

12. Is there a Trust? ( ) Yes ( ) No Name of Trust: _____
Is the Trust ( ) Revocable ( ) Irrevocable Tax ID# of Trust: _____

13. Is there a prepaid burial/funeral plan in place? ( ) Yes ( ) No If so, $ _____

14. Have any gifts been made? ( ) Yes ( ) No If so, when? _____
Amount of Gift $ _____

15. To whom was gift made? _____
_____

16. Comments/Notes: _____
_____
_____
_____
_____
_____

Pre-Screening Health Statement – Part A

	Client	Spouse (if applicable)
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
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
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
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
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: _____

List Medications or attach list

Medication	Dose	Frequency	Reason

2. Comments: _____
   _____
   _____
   _____

Spouse: _____ Height: _____ Weight: _____

3. **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: _____

List Medications or attach list

Medication	Dose	Frequency	Reason

4. Comments: _____
_____
_____
_____

MONTHLY INCOME:

Type	Husband Income	Wife Income
Social Security		
Pensions		
Interest/Dividends		
Income from IRA's		
Other		
Other		
Total		

ASSETS:

Real Estate	Description	Value	Outstanding Mortgage	Cost	Principal & Interest Payments	Taxes/Insurance Payment
Real Estate						
Own other property/real estate						

Checking/Savings Acct.	Owners of Acct.	Value of Acct.	Beneficiary ITF/POD/TOD
TOTAL			

C.D.'s/Money Markets	Owners of Acct.	Value of Acct.	Beneficiary ITF/POD/TOD
TOTAL			

IRA's	Owner	Investment Type	Value of Acct.	Surrender Value
TOTAL				

Brokerage Accounts Stocks/Bonds (EXCLUDING IRAS)	Owners	Value of Acct.	Cost	Beneficiary ITF/POD/TOD
TOTAL				

Annuities (Non IRA's)	Owner	Death Benefit	Cost	Surrender Value	Beneficiary ITF/POD/TOD
TOTAL					

Life Insurance	Owner	Death Benefit	Cost	Surrender Value	Beneficiary ITF/POD/TOD
TOTAL					

Other	Owner	Death Benefit	Cash Value	Cash Surrender Value
TOTAL				

Total Assets $ _____

Other Information you think we should know:

_____

_____

_____

_____