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Client Questionnaire

Client Information

Today's Date: _____

First Name	MI	Last Name	Date of Birth	Citizenship
SSN		Driver License #	State of Issue	Expiration
Home Phone		Cell Phone	Business Phone	Contact Preference? ❑ Email ❑ Phone ❑ Text
Email		State/Country of Birth		
Home Address				How Long? _____ Yrs _____ Mo
Employer Name				How Long? _____ Yrs _____ Mo
Occupation		Title		Annual Income
Employer Address				
Do you currently have life insurance? ❑ Yes ❑ No Insurance Carrier: Face Amount:			If yes, are you applying for insurance to replace it? ❑ Yes ❑ No Type: ❑ Term ❑ Permanent Is this a 1035 Exchange? ❑ Yes ❑ No	

Spouse/Partner Information

First Name	MI	Last Name	Date of Birth	Citizenship
SSN		Driver License #	State of Issue	Expiration
Home Phone		Cell Phone	Business Phone	Contact Preference? ❑ Email ❑ Phone ❑ Text
Email		What is the face amount of life insurance inforce on spouse/partner?		

Client Questionnaire

Dependent Information

First and Last Name	Date of Birth	Relationship	SSN
First and Last Name	Date of Birth	Relationship	SSN
First and Last Name	Date of Birth	Relationship	SSN
First and Last Name	Date of Birth	Relationship	SSN
Notes (Please include special needs, etc.)			

Advisors

CPA Name	Firm	Contact (Email or Phone)
Insurance Agent	Firm	Contact (Email or Phone)
Banker	Firm	Contact (Email or Phone)
Lawyer	Firm	Contact (Email or Phone)
Other Advisor	Firm	Contact (Email or Phone)

Parents' Information

Is there a history of diabetes, cancer, or heart disease in parents? If yes, please describe below:

Father: Age and health status –or– age at death and cause

Mother: Age and health status –or– age at death and cause

Additional family circumstances that should be discussed or taken into consideration:

Client Questionnaire

Medical Information

❑ Male ❑ Female

Height: _____ Weight: _____ Indicate change in weight from last year: _____

Primary Physician: _____

Primary Physician's Address: _____

Health Care Provider (Kaiser, Sharp, UCSD, VA, etc.): _____

Please select the following, if applicable:

Complication or disorder of…

- ❑ Heart or blood vessels, incl. chest pain, high blood pressure
- ❑ Stomach, liver, intestines, gallbladder, kidney or urinary tract
- ❑ Seizures, fainting, dizziness, epilepsy, stroke, or paralysis
- ❑ Nervous, mental or emotional disorder, or received counseling for any emotional condition
- ❑ Tumor, cancer, cysts or any disorder of the lymph nodes
- ❑ Back, spine, muscles, nerves, bones joints, incl. arthritis or gout
- ❑ Endocrine or glandular, incl. diabetes or thyroid
- ❑ Blood incl. anemia
- ❑ Respiratory system, incl. asthma, emphysema, sleep apnea, shortness of breath
- ❑ Eyes, ears, nose, throat
- ❑ Reproductive system or complications of pregnancy
- ❑ Allergies or skin disorders
- ❑ Mental or physical condition not listed above

Have you…

- ❑ Been diagnosed or treated for AIDS or a related condition
- ❑ Had surgery that has not been completed
- ❑ Been a patient in a hospital, sanatorium or other medical facility
- ❑ Been advised to have an EKG, x-ray, blood, urine or other diagnostic test
- ❑ Been under the treatment or care of a health care practitioner for any reason
- ❑ Ever used hallucinogenic or narcotic drugs not prescribed by a doctor
- ❑ Ever been treated for drug abuse or been advised to limit use of any medication
- ❑ Ever been treated for alcohol abuse or been advised to limit use of alcohol

Please provide details to any checked boxes above…

Are you currently taking medication of any kind? ❑ Yes ❑ No

If yes, please list and indicate whether the medication is prescribed or over-the-counter and the reason for taking

Client Questionnaire

Have you ever consumed alcohol? ❑ Yes ❑ No If yes, please describe:
Frequency: _____ Amount: _____ Date last used: _____

Have you ever used any form of tobacco (including pipe, cigar, chewing tobacco, vapes)? ❑ Yes ❑ No
If yes, please describe:
Type:_____ Frequency:_____ Amount: _____ Date last used:_____

Within the past 5 years, have you ever been convicted of a felony? ❑ Yes ❑ No If yes, please describe:

Within the past 5 years, have you had any accidents, moving violations, or your driver's license suspended or revoked? ❑ Yes ❑ No If yes, please describe:

Within the next 2 years, do you plan to fly, or within the last 2 years have you flown as a pilot, student pilot, or crew member? ❑ Yes ❑ No If yes, please describe:

Within the next 2 years, do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing?
❑ Yes ❑ No If yes, please describe:

Within the next 2 years, do you plan or expect to travel or reside outside the USA? *Please consider "Yes" only if flights and housing have been secured.* If yes, please describe (where, when, duration, business or pleasure, etc.):