



WALNUT CREEK • SACRAMENTO

BOLD, POLISNER, MADDOW, NELSON & JUDSON

ESTATE PLANNING INITIAL CLIENT QUESTIONNAIRE – COUPLES

Date: _____ Referred By (If Applicable): _____

ARAG Member and ID (If Applicable): _____

Client #1 (Full Name): _____

Any Additional Names such as Maiden or Nicknames: _____

Mailing Address: _____

Residential Address (If different): _____

Social Security Number: _____

Best Telephone No.: _____ E-mail: _____

Can we use email to communicate with you and send drafts? Yes or No

Date and Place of Birth: ____/____/____ _____

Employer & Job Title: _____

Work Address: _____

Work Telephone: _____ Work Email: _____

Are you a U.S. Citizen? Yes or No Date of Naturalization (if applicable): ____/____/____

Do you or a former deceased spouse have a service-connected disability rating from the U.S. Department of Veterans Affairs? Yes

Client #2 (Full Name): _____

Any Additional Names such as Maiden or Nicknames: _____

Mailing Address: _____

Social Security Number: _____

Best Telephone No.: _____ E-mail: _____

Can we use email to communicate with you? Yes or No

Date and Place of Birth: ____/____/____ _____

Employer & Job Title: _____

Work Address: _____

Work Telephone: _____ Work Email: _____

Are you a U.S. Citizen? Yes or No Date of Naturalization (if applicable): _____



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PRIOR MARRIAGES (If Applicable)

Prior Marriage(s): Client #1

1) Former Spouse's Name: _____
Date of Dissolution: _____
County and State of Dissolution: _____

2) Former Spouse's Name: _____
Date of Dissolution: _____
County and State of Dissolution: _____

Prior Marriage(s): Client #2

1) Former Spouse's Name: _____
Date of Dissolution: _____
County and State of Dissolution: _____

2) Former Spouse's Name: _____
Date of Dissolution: _____
County and State of Dissolution: _____

Additional Notes on Marriages of Client #1:

Additional Notes on Marriages of Client #2:



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CHILDREN

Child #1: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #1: _____

Living or Deceased Date of Death (If Applicable): _____

Child #2: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #2: _____

Living or Deceased Date of Death (If Applicable): _____

Child #3: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #3: _____

Living or Deceased Date of Death (If Applicable): _____

Child #4: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #4: _____

Living or Deceased Date of Death (If Applicable): _____



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Child #5: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #1: _____

Living or Deceased Date of Death (If Applicable): _____

Child #6: Full Legal Name: _____

D/B: ____ / ____ / ____

Address: _____

Parents of Child #2: _____

Living or Deceased Date of Death (If Applicable): _____

Additional Notes on Children of Client #1:

Additional Notes on Children of Client #2:



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GUARDIAN(S) OF MINOR CHILDREN

Guardian of the Person for Minor Children (under age 18) – with whom your children will reside if both parents are deceased:

Name #1: _____ Primary or Alternate
Relationship: _____
Address: _____
Telephone: _____ E-mail: _____

Name #2: _____ Primary or Alternate
Relationship: _____
Address: _____
Telephone: _____ E-mail: _____

Name #3: _____ Primary or Alternate
Relationship: _____
Address: _____
Telephone: _____ E-mail: _____

Name #4: _____ Primary or Alternate
Relationship: _____
Address: _____
Telephone: _____ E-mail: _____



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**TRUSTEES/EXECUTORS/FINANCIAL AGENTS/
GUARDIANS OF THE ESTATE FOR MINORS**

If you pass, who would you like to manage your financial affairs?

Surviving Spouse: Yes No

Do you both wish for the Surviving Spouse to have the power to amend and manage the Trust?

Yes or No

Name #1: _____ Primary or Alternate

Relationship: _____

Address: _____

Telephone: _____ E-mail: _____

Name #2: _____ Primary or Alternate

Relationship: _____

Address: _____

Telephone: _____ E-mail: _____

Name #3: _____ Primary or Alternate

Relationship: _____

Address: _____

Telephone: _____ E-mail: _____

Name #4: _____ Primary or Alternate

Relationship: _____

Address: _____

Telephone: _____ E-mail: _____



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Do you wish for the same individual(s) listed above to make financial decisions outside of your trust if you are incapacitated? [The typical answer is “Yes” for continuity] Yes No

If your answer is no, who would you like your agent(s) to be to make financial decisions outside of the trust if you are incapacitated?

Surviving Spouse: Yes No

Name #1: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

Name #2: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

Name #3: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

Do you have a premarital or post-marital agreement of any type? (If yes, please provide a copy.)

Yes No

Do you now have a written community property agreement? (If yes, please provide a copy.)

Yes No

Do you anticipate any challenges to your estate plan and/or wish to specifically disinherit any relatives?

Yes No

If yes, please specify:



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DISTRIBUTION OF ASSETS

Specific Gifts (Gifts of Jewelry, Artwork, etc. that are to be given to a specific individual):

Do you wish to make any specific gifts of money or property to anyone? Yes No

If yes, please specify below:

Name of Beneficiary: _____

Relationship: _____

Phone: _____

Gift (Item or amount): _____

Name of Beneficiary: _____

Relationship: _____

Phone: _____

Gift (Item or amount): _____

Name of Beneficiary: _____

Relationship: _____

Phone: _____

Gift (Item or amount): _____

Name of Beneficiary: _____

Relationship: _____

Phone: _____

Gift (Item or amount): _____

Name of Beneficiary: _____

Relationship: _____

Phone: _____

Gift (Item or amount): _____



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The Remaining Estate will be divided between the following named persons:

Children: _____

Others: _____

Charities: _____

In Equal Shares? Yes No By Percentage? Yes No

Specific Value or Dollar Amount? Yes No

Explain: _____

Would you like your children or others named above to receive their inheritance right away?

Yes No

If not, under what circumstances, age(s), or events would you like inheritance to be received?

Explain: _____

Do any of your beneficiaries have special needs? If so, who? _____

What is the nature of the special need(s)? _____

Special Instructions or Desires? _____

Do you have any special estate and income tax considerations you would like to discuss?



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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

AGENT(S) TO MAKE HEALTH CARE DECISIONS IF YOU ARE INCAPACITATED:

Spouse As Primary Agent For Both? Yes No

For Client #1:

Name #1: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

Name #2: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

Name #3: _____ Primary or Alternate

Address: _____

Telephone: _____ E-mail: _____

DONATION OF BODY PARTS AND/OR ORGANS

Upon my death (choose (a) or (b) or (c), and also (d):

- (a) I do not wish to be an organ donor.
- (b) I give any needed organs, tissues, or parts
- (c) I give only the following organs, tissues, or parts:

(d) My gift is for the following purposes:

- Transplant Therapy None
- Research Education

BURIAL/CREMATION INSTRUCTIONS: _____

RELIGIOUS BELIEFS TO BE FOLLOWED, IF ANY: _____



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For Client #2:

Name #1: _____ Primary or Alternate
Address: _____
Telephone: _____ E-mail: _____

Name #2: _____ Primary or Alternate
Address: _____
Telephone: _____ E-mail: _____

Name #3: _____ Primary or Alternate
Address: _____
Telephone: _____ E-mail: _____

DONATION OF BODY PARTS AND/OR ORGANS

Upon my death (choose (a) or (b) or (c), and also (c):

- (a) I do not wish to be an organ donor.
- (b) I give any needed organs, tissues, or parts
- (c) I give only the following organs, tissues, or parts:

(d) My gift is for the following purposes:

- Transplant Therapy None
- Research Education

BURIAL/CREMATION INSTRUCTIONS: _____

RELIGIOUS BELIEFS TO BE FOLLOWED, IF ANY: _____



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END OF LIFE WISHES

Client #1

Under what circumstances are machines/mechanical interventions/respirators to be used?

Under what circumstances are machines/mechanical interventions/respirators to be discontinued?

Do you approve of the placement of a feeding tube for short-term or long-term care? If so, under what circumstances should a feeding tube be withdrawn?

Except as I state in the following space, I direct that treatment for alleviation or pain or discomfort be provided at all times, even if it hastens my death:

OTHER CONSIDERATIONS:

Client #2

Under what circumstances are machines/mechanical interventions/respirators to be used?

Under what circumstances are machines/mechanical interventions/respirators to be discontinued?

Do you approve of the placement of a feeding tube for short-term or long-term care? If so, under what circumstances should a feeding tube be withdrawn?

Except as I state in the following space, I direct that treatment for alleviation or pain or discomfort be provided at all times, even if it hastens my death:

OTHER CONSIDERATIONS:



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ASSET INFORMATION

CASH AND BANK ACCOUNTS:

Amount of cash held at home: _____

Bank Name and Branch: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Bank Name and Branch: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Bank Name and Branch: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Account Number: _____ Type: _____ Balance: _____

Do you have a Safe Deposit Box? Yes: No:

(If yes, where is it located? Please specify below. If more than one, please provide location of each)

Name of Institution _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Name of owner(s): _____

List of Contents: _____

[Attach Additional Sheet If Necessary]



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NON-RETIREMENT INVESTMENTS

Stocks, Bonds, Brokerage Accounts: [Attach recent statement for each account]

Brokerage Account: _____ Balance: _____
Address: _____
Stock Broker: _____ Telephone: _____
Account Numbers: _____

Brokerage Account: _____ Balance: _____
Address: _____
Stock Broker: _____ Telephone: _____
Account Numbers: _____

Brokerage Account: _____ Balance: _____
Address: _____
Stock Broker: _____ Telephone: _____
Account Numbers: _____

Brokerage Account: _____ Balance: _____
Address: _____
Stock Broker: _____ Telephone: _____
Account Numbers: _____

Stock Certificates Held By Client: [Attach copy of Certificates]

Company Name: _____ No. of Shares: ____ CUSIP _____
Company Name: _____ No. of Shares: ____ CUSIP _____
Company Name: _____ No. of Shares: ____ CUSIP _____
Company Name: _____ No. of Shares: ____ CUSIP _____

Location of Certificates: _____



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RETIREMENT ACCOUNTS/PENSION/IRA/401k/ETC.:

[Attach recent statement for each account]

Company Name: _____

Owner: _____

Account No.: _____

Account Value: _____

Current Beneficiary: 1. _____

2. _____

Company Name: _____

Owner: _____

Account No.: _____

Account Value: _____

Current Beneficiary: 1. _____

2. _____

Company Name: _____

Owner: _____

Account No.: _____

Account Value: _____

Current Beneficiary: 1. _____

2. _____

Company Name: _____

Owner: _____

Account No.: _____

Account Value: _____

Current Beneficiary: 1. _____

2. _____

Company Name: _____

Owner: _____

Account No.: _____

Account Value: _____

Current Beneficiary: 1. _____

2. _____



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REAL PROPERTY:

[Attach copy of Deeds If Possible]

Primary Residence

Address: _____

Assessor's Parcel Number: _____

Form of Title: _____

Percentage Ownership: _____

Date of Occupancy: _____

Names of Occupants: _____

Other Real Property

Address #1: Rental Property? Yes No

Assessor's Parcel Number: _____

Form of Title: _____

Percentage Ownership: _____

Names of Occupants: _____

Address #2: Rental Property? Yes No

Assessor's Parcel Number: _____

Form of Title: _____

Percentage Ownership: _____

Names of Occupants: _____

Address #3: Rental Property? Yes No

Assessor's Parcel Number: _____

Form of Title: _____

Percentage Ownership: _____

Names of Occupants: _____



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OTHER ASSETS

Promissory Notes – (Money Owed To You)

Do you hold any Promissory Notes? Yes: No:

[Attach Copy of Promissory Notes and Deeds of Trust]

Name: _____	Amount: \$ _____	Date Due: _____
Name: _____	Amount: \$ _____	Date Due: _____
Name: _____	Amount: \$ _____	Date Due: _____

Business Interests – (Partnerships/Corporations/LLCs): [Attach copy of Formation Agreements]

Are You A Partner/Member In Any Partnership, Corporation, or LLC? Yes: No:

Company #1: _____	Capitol Investment: \$ _____
Percentage Ownership: _____	Form of Entity (Partnership, Corporation, LLC?): _____

Company #2: _____	Capitol Investment: \$ _____
Percentage Ownership: _____	Form of Entity (Partnership, Corporation, LLC?): _____

Company #3: _____	Capitol Investment: \$ _____
Percentage Ownership: _____	Form of Entity (Partnership, Corporation, LLC?): _____



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LIFE INSURANCE:

Life Insurance Company: _____ **Policy #:** _____

Broker Name: _____ **Telephone:** _____

Address: _____

Face Amount: _____ **Term** **Whole Life** **Universal**

Owner: _____

Beneficiary(s): _____

Life Insurance Company: _____ **Policy #:** _____

Broker Name: _____ **Telephone:** _____

Address: _____

Face Amount: _____ **Term** **Whole Life** **Universal**

Owner: _____

Beneficiary(s): _____

Life Insurance Company: _____ **Policy #:** _____

Broker Name: _____ **Telephone:** _____

Address: _____

Face Amount: _____ **Term** **Whole Life** **Universal**

Owner: _____

Beneficiary(s): _____

Life Insurance Company: _____ **Policy #:** _____

Broker Name: _____ **Telephone:** _____

Address: _____

Face Amount: _____ **Term** **Whole Life** **Universal**

Owner: _____

Beneficiary(s): _____



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Furniture, Furnishing, Jewelry and Other Items of Value: [Attach copy of Appraisals]

List Special Value Items:

AUTOMOBILES

Make: _____	Model: _____	Year: _____	VIN: _____
Make: _____	Model: _____	Year: _____	VIN: _____
Make: _____	Model: _____	Year: _____	VIN: _____
Make: _____	Model: _____	Year: _____	VIN: _____

Other Assets of Value:

Any Other Notes?
