

CARE MANAGEMENT QUESTIONNAIRE

This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Bring this information with you to the appointment.

Date _____ File No. _____ File Name _____

1. CLIENT

A. Full Name of Client _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail Address _____ Social Security No. _____

Version of Software: WordPerfect Word Other _____

B. Marital Status: Married Single

Divorced Widowed - Date of Death _____

C. Birth Information:

Date of Birth _____ Place of Birth _____

Became a Virginia Resident (approximate date) _____

Citizen of: USA Other _____

D. Primary Physician Information:

Name of Physician _____

Street Address _____

City _____ State _____ Zip _____

E. Health Care Insurance and Medical Information:

Medicare # _____

Medicaid # _____

Allergies: _____

Diagnosed illnesses: _____

Health Care Plan: _____

Agent under Advance Medical Directive: _____

Hospital preference: _____

Pharmacy: _____

List of Prescription Medication and Dosages (write in pencil for quick changes)

1. _____

2. _____

3. _____

4. _____

5. _____

F. Community References:

Close Neighbors: _____ Phone number _____

_____ Phone number _____

Friends: _____ Phone number _____

_____ Phone number _____

_____ Phone number _____

Lawn Care: _____ Phone number _____

Church attended _____ Phone number _____

Church Clergy _____ Phone number _____

Clubs/Organizations: _____

Veterinarian: _____ Phone number _____

Hairdresser: _____ Phone number _____

G. Veteran's Information:

VA ID Number _____

Dates of Service _____ Branch of Service _____

2. **CONTACT**

Full Name of Contact _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail Address _____ Social Security No. _____

Relationship to Client _____

Version of Software: WordPerfect Word Other _____

3. CLIENT'S SPOUSE

If Client's spouse is different than the Contact above, furnish the following information:

Full Name of Spouse _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail Address _____ Social Security No. _____

Version of Software: WordPerfect Word Other _____

4. CLIENT'S CHILDREN (if applicable)

A. Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail Address _____ Social Security No. _____

Date of Birth _____

B. Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No _____

E-mail Address _____ Social Security No _____

Date of Birth _____

C. Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No _____

Cell Phone No. _____ Fax No _____

E-mail Address _____ Social Security No _____

Date of Birth _____

5. NURSING HOME/ASSISTED LIVING FACILITY

Full Name of Nursing Home/Assisted Living Facility _____

Street Address _____

City _____ State _____ Zip _____

Facility Phone No _____

Full Name of Contact _____

Contact's Direct Phone No. _____ Cell Phone No _____

Fax No. _____ E-mail Address _____

6. CLIENT'S ACCOUNTANT

Name of Accountant _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail Address _____

7. CLIENT'S INSURANCE AGENTS

Life Insurance Agent _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail Address _____

Car Insurance Agent _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail Address _____

Home Owner's Agent _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No _____

E-mail Address _____

8. CLIENT'S STOCK BROKER

Name of Stock Broker _____

Name of Account Representative _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No _____

E-mail Address _____

9. OTHER PROFESSIONAL ADVISORS

A. Name _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No _____

E-mail Address _____

B. Name _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No _____

E-mail Address _____

10. OUTSTANDING DEBT

A. Name of Creditor _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail Address _____
Amount of Debt: \$ _____

B. Name of Creditor _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail Address _____
Amount of Debt: \$ _____

C. Name of Creditor _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No. _____
E-mail Address _____
Amount of Debt: \$ _____

11. REAL ESTATE

Addresses of All Real Estate Owned by Client:

A. Street Address _____

City _____ State _____

Tax Block # _____, Lot # _____ (obtained from tax bill)

Joint Ownership - Is property owned with someone else? Yes No

B. Street Address _____

City _____ State _____

Tax Block # _____, Lot # _____ (obtained from tax bill)

Joint Ownership - Is property owned with someone else? Yes No

12. MONTHLY INCOME

Provide monthly income and income sources which client receives:

Social Security \$ _____

Pension with _____ \$ _____

Annuity with _____ \$ _____

Rent _____ \$ _____

Other _____ \$ _____

Other _____ \$ _____

13. RECEIVABLES

List any receivables to which the client was entitled (i.e., Notes, Mortgages, Unsecured Debts):

A. Name of Debtor _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No _____
E-mail Address _____
Amount of Receivable: \$ _____

B. Name of Debtor _____
Street Address _____
City _____ State _____ Zip _____
Phone No. _____ Fax No _____
E-mail Address _____
Amount of Receivable: \$ _____

14. PRIOR GIFTS

Did Client make any gifts in excess of \$10,000 in any calendar year to any one individual?
 Yes No

If yes, please attach a list of the names and addresses of the recipients, the dates, and the amounts.

15. SAFE DEPOSIT BOX

Name of Bank _____
Name of Contact Person _____

Branch - Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Fax No. _____

E-mail Address _____

Name(s) in Which Box Was Held _____

16. MISCELLANEOUS

Have you visited our Website at www.oasthook.com? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

17. CERTIFICATION

The undersigned hereby represents to Oast & Hook P.C., and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. The undersigned understands that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client:
