WILL & POWERS OF ATTORNEY QUESTIONNAIRE

LOCATION OF APPPOINTMENT: ☐ Peoria ☐ Morton ☐ Telephone ☐ Other **DATE:** _____

How did you hear about us?

☐ Radio ☐ Printed Ad ☐ Facebook ☐ Referral from a former client: _____
☐ Referral from an attorney: _____ ☐ Referral from a friend _____
☐ Google Search ☐ I am a previous client ☐ Other (please explain)_____

CLIENT

_____
Name - First Middle Last (Maiden)

_____
Address - Street County City State Zip

_____ _____ _____ _____
Years of Schooling Degrees, Certificates, etc. Date of Birth Length of Residence in Illinois

_____ _____ _____ _____
Home phone Work phone Cell phone email address

(For Office Use Only): Full Conflict Check Completed By: ☐

SPOUSE OR CIVIL UNION PARTNER, if applicable

_____
Name - First Middle Last (Maiden)

_____
Date of Birth Home phone Work phone Cell phone

CHILDREN

	FULL NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
1.				
2.				
3.				
4.				
5.				

Any adoptions? _____ Is Spouse Expecting? _____

CLIENT'S PARENTS:

_____

_____

SPOUSE'S PARENTS:

_____

_____

CLIENT'S BROTHER/SISTERS:

_____ _____

_____ _____

_____ _____

SPOUSE'S BROTHER/SISTERS:

_____ _____

_____ _____

_____ _____

EXECUTOR OF THE ESTATE:

1ST Choice Name_____Phone_____

Address _____

2ND Choice Name_____Phone_____

Address _____

3RD Choice Name_____Phone_____

Address _____

GUARDIAN OF THE ESTATE: (of minor or disabled children)

1ST Choice Name_____Phone_____

2nd Choice Name_____Phone_____

GUARDIAN OF THE PERSON: (of minor or disabled children)

1ST Choice Name_____Phone_____

2nd Choice Name_____Phone_____

BANK'S NAME: (As Trustee of the Children's Trust)

_____ **TRUST TO TERMINATE AT AGE:** _____

DO YOU HAVE ANY SPECIFIC BELONGINGS OR ASSETS THAT YOU WANT TO GO DIRECTLY TO A SPECIFIC PERSON OR ORGANIZATION? IF SO, LIST THE PERSON/ENTITY'S NAME AND THE ITEM(S) THEY ARE TO RECEIVE BELOW.

_____	_____
Person	Bequest
_____	_____
Person	Bequest

DOES YOUR APPROXIMATE NET WORTH (INCLUDING INSURANCE BENEFITS) EXCEED $1.5 MILLION? Yes _____ No _____

SPECIAL NOTES/COMMENTS:_____

_____

_____

_____

_____

_____

_____

POWER OF ATTORNEY FOR HEALTH CARE:

CLIENT TO COMPLETE

1ST AGENT Name _____ Phone _____

Address _____

2ND AGENT Name _____ Phone _____

Address _____

3RD AGENT Name _____ Phone _____

Address _____

SPOUSE TO COMPLETE

1ST AGENT Name _____ Phone _____

Address _____

2ND AGENT Name _____ Phone _____

Address _____

3RD AGENT Name _____ Phone _____

Address _____

I WANT MY AGENT TO: (select one)

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. OR

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. OR

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES:

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain. OR

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:
The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically below:_____

EFFECTIVE and TERMINATION DATES:

1. You may choose to make your power of attorney effective upon signing so that your agent may act whenever you are not capable of acting. If, however, you prefer to require a physician's opinion that you are incapacitated before your agent can act on your behalf, or have another triggering event in mind, you may explain here.
   This power of attorney shall become effective on _____
   (Note: You may choose a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

2. By law, your power of attorney will terminate upon your death.
   This power of attorney shall terminate on _____
   (Note: You may choose a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)

POWER OF ATTORNEY FOR PROPERTY:

CLIENT TO COMPLETE

AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

SPOUSE TO COMPLETE

AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

SUCCESSOR AGENT Name _____ Phone _____

Address _____

