**Financial Planning Form**

|  |  |
| --- | --- |
| Date Completed: |       |

**This document is strictly confidential. Your information will be not be shared.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Citizenship:** |       |  **SS #:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Driver’s License State:** |       |  **Driver’s License ID #:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Driver’s License Issued Date:** |       |  **Driver’s License Expiration Date:** |       |

|  |  |
| --- | --- |
| **Home Address:** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How long have you lived at this address?** |       |  **Do You:** | **Own [ ]**  | **Rent** **[ ]**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cell Phone:** |       | **Email:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Height:** |       |  **Weight:** |       |  **Primary Doctor:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Do you smoke?** | **Yes [ ]**  | **No [ ]**  | **Do you take prescription medications?** | **Yes [ ]**  | **No [ ]**  |

|  |  |
| --- | --- |
| **If yes, please list medications.** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Spouse Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Citizenship:** |       |  **SS #:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Driver’s License State:** |       |  **Driver’s License ID #:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Driver’s License Issued Date:** |       |  **Driver’s License Expiration Date:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Cell Phone:** |       | **Email:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Height:** |       |  **Weight:** |       |  **Primary Doctor:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Does your spouse smoke?** | **Yes [ ]**  | **No [ ]**  | **Does your spouse take prescription medications?** | **Yes [ ]**  | **No [ ]**  |

|  |  |
| --- | --- |
| **If yes, please list medications.** |  |

**OCCUPATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Job Title:** |       | **Employer:** |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Street Address:** |       | **City:** |       | **State:** |       | **Zip:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Phone Number:** |       | **# of Years Employed:** |       | **Income:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Spouse Job Title:** |       | **Employer:** |       |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Street Address:** |       | **City:** |       | **State:** |       | **Zip:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Phone Number:** |       | **# of Years Employed:** |       | **Income:** |       |

**DEPENDENTS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have any children?** | **Yes [ ]**  | **No [ ]**  | **If yes, how many?** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |
| **Occupation:** |       |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |
| **Occupation:** |       |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |
| **Occupation:** |       |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |
| **Occupation:** |       |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name:** |       |  **M [ ]**  |  **F [ ]**  |  **Date of Birth**: |       |
| **Occupation:** |       |  |

|  |  |
| --- | --- |
| **How do you feel about saving for children’s college education?** |       |

|  |  |  |
| --- | --- | --- |
| **Have you implemented any kind of savings plans yet?** | **Yes [ ]**  | **No [ ]**  |

**RESIDENCE**

|  |  |  |  |
| --- | --- | --- | --- |
| VALUE | REMAINING MORTGAGE | INTEREST RATE | YEARS LEFT |
|       |       |       |       |

**INSURANCE**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| INSURED | COMPANY | POLICY # | YEAR ISSUED | TYPE | FACE AMT | ANNUAL PREMIUM | CURRENT CASH VALUE |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |

|  |  |  |
| --- | --- | --- |
| **Do you have any long-term care insurance policies?** | **Yes [ ]**  | **No [ ]**  |

|  |  |
| --- | --- |
| **If yes, please specify:** |  |

|  |  |  |
| --- | --- | --- |
| **Do you have any special interests or health conditions that could affect your insurance planning?** |  **Yes [ ]**  |  **No [ ]**  |

|  |  |  |
| --- | --- | --- |
| **If yes, please specify:** | Client |       |

|  |  |  |
| --- | --- | --- |
|  | Spouse |       |

**LIABILITIES**

|  |  |  |  |
| --- | --- | --- | --- |
|  | MONTHLY |  | ANNUALLY |
| Mortgage |       |  |       |
| Utilities |       |  |       |
| Cable |       |  |       |
| Home Phone |       |  |       |
| Cell Phone |       |  |       |
| Food |       |  |       |
| Car Payments |       |  |       |
| Car Insurance |       |  |       |
| Life Insurance |       |  |       |
| 529 Plan |       |  |       |
| Credit Cards |       |  |       |
| Entertainment |       |  |       |
| Monthly Dues / Membership Fees |       |  |       |
| **TOTAL EXPENSES** |       |  |       |
| **TOTAL TAXES** |       |  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is there any income from other sources?** | **Yes [ ]**  | **No [ ]**  | **Source:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Attorney:** |       |  **Phone #:** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Accountant:** |       |  **Phone #:** |       |

**ASSETS**

**Do you own any of the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  TYPE | VALUE |  | OWNED BY |  | FINANCIAL INSTITUTION |
| [ ]  Savings |  |  |  |  |  |
| [ ]  Checking |  |  |  |  |  |
| [ ]  CD |  |  |  |  |  |
| [ ]  T Bills |  |  |  |  |  |
| [ ]  Tax-free Bond Funds |  |  |  |  |  |
| [ ]  Income Funds |  |  |  |  |  |
| [ ]  IRAs |  |  |  |  |  |
| [ ]  401K |  |  |  |  |  |
| [ ]  Pension |  |  |  |  |  |
| [ ]  Credit Unions |  |  |  |  |  |
| [ ]  Stocks |  |  |  |  |  |
| [ ]  Mutual Funds |  |  |  |  |  |

|  |  |
| --- | --- |
| **What are your investment goals?** |       |

|  |  |  |
| --- | --- | --- |
| **Are you happy with your rate of return?** | **Yes [ ]**  | **No [ ]**  |

**THANK YOU.**