LAW OFFICE OF
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Toolkit Worksheet

Who is this for?	☐ Self ☐ Relative ☐ Friend
Full Legal Name*	
Legal Alias*	
Full Name of Mother*	
Mother's Birth Name*	
Full Name of Father*	
Social Security Number*	
Date of Birth*	
Place of Birth*	
Driver's License	
Name of Spouse	
Employer's Name/Number	
Occupation/# of years*	
Education*Degree/Location	

**Required information for death certificate*

Close Friends/Neighbors/Caregivers

First Name	Last Name	Middle Initial
Address		
City	State	Zip Code
Phone	Other	
First Name	Last Name	Middle Initial
Address		
City	State	Zip Code
Phone	Other	
First Name	Last Name	Middle Initial
Address		
City	State	Zip Code
Phone	Other	

Where are important documents located?

Document Type:	Location:
Birth Certificate	
Marriage License	
Divorce Decree	
Trust/Will	
Power of Attorney	
Health Care Directive	
Life Insurance Policy	
Last income tax return	
Safe Deposit Box	
Stocks/Bonds/Mutual's	
Deeds to Real Property	
Funeral Policy	

If there are Estate planning documents, Name of Attorney

First Name	Last Name	
Company Name		
Address		
City	State	Zip Code
Phone	Other	

Have they made their wishes known for end of life situations?

1. Life Support?
2. Pain Relief?
3. Donation of Organs?
4. Disposition of remains?

Name of Accountant

First Name	Last Name	
Company Name		
Address		
City	State	Zip Code
Phone Number	Other	

Name Financial Planner

First Name	Last Name	
Company Name		
Address		
City	State	Zip Code
Phone Number	Other	

Financial Information

Creditor Name	Account Number	Phone Number	Username/Password

Bank Name	Account Number	Phone Number	Username/Password

Beneficiaries

Have they assigned beneficiaries to any asset not in the trust such as IRAs, 401Ks, insurance policies?

Insurance/401K	Account Number	Phone Number	Username/Password

Medical Emergency Information

Last Name	First Name	Middle Initial	
Date of Birth	Sex	Weight	Blood Type
Address			
City	State	Zip Code	
Primary Insurance Co.	Secondary Insurance Co.		
Primary Insurance Numbers & Group	Secondary Insurance Numbers & Group		

Past Medical History

Allergies

☐ None
☐ Unknown

Medical Allergies:

_____

_____

_____

_____

_____

_____

Cardiac

☐ None
☐ Unknown
☐ Angina
☐ Arrhythmia
☐ Cardiomyopathy
☐ CHF
☐ Congenital
☐ Implanted Defib
☐ MI

Other:

_____

Surgery

☐ None
☐ Unknown
☐ Abdominal
☐ Heart
☐ Lung
☐ Neurological

Other:

_____

_____

_____

Chronic Illnesses

☐ None
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ COPD
☐ CVA / TIA
☐ Diabetic
☐ Dialysis/Renal
☐ Gastrointestinal
☐ Headaches
☐ Hepatitis
☐ HIV +
☐ Hypertension
☐ Paralysis
☐ Psychological
☐ Seizures
☐ Substance Abuse
☐ TB
☐ Unknown

Other:

_____

Current Medications

☐ None ☐ Unknown

_____

_____

Primary Physician (Name & Address) Physician Phone Number

_____ _____