



CASH FLOW QUESTIONNAIRE

ITEM

MONTHLY

ANNUAL

HOUSING

House payment

Rent payment

Lease payment (not mortgage)

Property improvements

Home association dues

Household incidentals (supplies)

Household furnishings

Other: _____

Other: _____

Subtotal:

FOOD

Groceries

Dining out

Other: _____

Other: _____

Subtotal:

CLOTHING

Clothing

Dry cleaning

Other: _____

Other: _____

Subtotal:

PERSONAL CARE

(hair styling, etc.)

Other: _____

AUTOMOBILE

Monthly payment

Operating expenses (gas, oil, etc.)

Maintenance

Lease payment

Other: _____

Subtotal:



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<u>ITEM</u>		<u>MONTHLY</u>	<u>ANNUAL</u>
 PROPERTY TAX			
Automobile		_____	_____
House		_____	_____
Boat		_____	_____
Trailer		_____	_____
Other: _____		_____	_____
	Subtotal:	_____	_____
 UTILITIES			
Telephone		_____	_____
Cellular Phone		_____	_____
Water		_____	_____
Electric		_____	_____
Gas		_____	_____
Trash Removal		_____	_____
Cable		_____	_____
Other: _____		_____	_____
Other: _____		_____	_____
	Subtotal:	_____	_____
 ENTERTAINMENT			
Books		_____	_____
Newspaper		_____	_____
Movies (theatre, video, plays, etc.)		_____	_____
Club dues (golf, music, etc.)		_____	_____
Other: _____		_____	_____
Other: _____		_____	_____
	Subtotal:	_____	_____
 PROFESSIONAL EXPENSES			
Travel		_____	_____
Vehicle rental		_____	_____
Parking		_____	_____
Lodging		_____	_____
Meals		_____	_____
Entertainment		_____	_____



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Other:	_____	_____	_____
Other:	_____	_____	_____
	Subtotal:	_____	_____
 ALIMONY (paid)			
	Subtotal:	_____	_____
 CHILD SUPPORT (paid)			
	Subtotal:	_____	_____
 CHILD CARE			
Daycare		_____	_____
Domestic help (babysitter)		_____	_____
Other:	_____	_____	_____
	Subtotal:	_____	_____
 GIFTS			
Birthdays		_____	_____
Christmas		_____	_____
Anniversaries		_____	_____
Other:	_____	_____	_____
	Subtotal:	_____	_____
 CHARITABLE CONTRIBUTIONS			
(Churches, schools, etc)		_____	_____
Other:	_____	_____	_____
Other:	_____	_____	_____
	Subtotal:	_____	_____
 MEDICAL EXPENSES			
Doctor visit co-pay		_____	_____
Prescription co-pay		_____	_____
Dental Care		_____	_____
Vision Care		_____	_____
Other:	_____	_____	_____
	Subtotal:	_____	_____
 INSURANCE			
Health		_____	_____

