

CLIENT QUESTIONNAIRE - PERSONAL INJURY EVALUATION

DATE OF ACCIDENT _____ STATUTE DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____

HOME PHONE # _____

CITY _____ WORK PHONE # _____

STATE _____ ZIP _____

SOCIAL SECURITY# _____ MARITAL STATUS _____

SPOUSE'S NAME _____ MAIDEN NAME _____

Names of children; dates of birth and addresses (if different):

Names and addresses of living parents:

ALTERNATE CONTACTS:

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

Relationship _____ Relationship _____

CLIENT REFERRED BY:

Name _____

Address _____

CONFLICT OF INTEREST:

N A M E (S) O F O P P O S I N G P A R T I E S :

OPPOSING COUNSEL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____ CLAIM NO. _____

OPPOSING INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

OPPOSING INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

CLIENT'S HEALTH INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

_____ DATE COPY OF SUBROGATED PAYMENTS MADE REQUESTED

_____ DATE RECEIVED _____ AMOUNT

CLIENT'S HEALTH INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

_____ DATE COPY OF SUBROGATED PAYMENTS MADE REQUESTED

_____ DATE RECEIVED _____ AMOUNT

CLIENT'S AUTO INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

_____ DATE COPY OF SUBROGATED PAYMENTS MADE REQUESTED

_____ DATE RECEIVED _____ AMOUNT

VEHICLE OWNER'S INSURANCE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

REPRESENTATIVE _____

TELEPHONE NO. _____ CLAIM NO. _____

_____ DATE COPY OF SUBROGATED PAYMENTS MADE REQUESTED

_____ DATE RECEIVED _____ AMOUNT

WITNESS/PASSENGER NAME

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

TYPE OF TESTIMONY _____

WITNESS/PASSENGER NAME

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

TYPE OF TESTIMONY _____

WITNESS/PASSENGER NAME

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

TYPE OF TESTIMONY _____

WITNESS/PASSENGER NAME

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

TYPE OF TESTIMONY _____

PLAINTIFF'S PHYSICIANS/HEALTH CARE PROVIDERS

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

REQUEST FOR MEDICAL RECORDS:

SENT _____ RECEIVED _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

REQUEST FOR MEDICAL RECORDS:

SENT _____ RECEIVED _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

REQUEST FOR MEDICAL RECORDS:

SENT _____ RECEIVED _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

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SENT _____ RECEIVED _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

REQUEST FOR MEDICAL RECORDS:

SENT _____ RECEIVED _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NO. _____

REQUEST FOR MEDICAL RECORDS:

SENT _____ RECEIVED _____

EMPLOYMENT

Present Employer _____

Address _____

Phone _____ Supervisor _____ Time Employed _____

Nature of your job description _____

Time lost since injury _____ Wage Scale _____

Former Employers (at least 5 years before injury):

Name	Address	Type of Work	Dates Employed

Spouse's Employer _____

Address _____

Phone _____ Soc. Sec. # _____

Supervisor _____

Have you ever file a worker's compensation claim _____ (yes/no)

If yes, name of insurance company _____

Phone No. _____ Name of Contact Person _____

Have you ever been involved in any other legal action? _____ (yes/no)

If yes, briefly describe _____

Military status and history (if any) _____

Have you ever been convicted of a misdemeanor or felony? _____ (yes/no)

Have you filed income tax returns for the past 5 years? _____ (yes/no)

If so, are the names and addresses different from above? _____ (yes/no)

If yes, what are the names and addresses? _____

Do you have copies of the returns? _____ (yes/no)

OCCURRENCE INFORMATION

Have you given anyone a written or recorded statement concerning the events of this incident? _____(yes/no)

If yes, to whom?_____

In order to better serve your interests, we would like you to prepare a written chronology of the events of this occurrence. Please include the following:

1. The first contact with the defendant (when and by what method)
2. Describe in narrative form what occurred on initial contact
3. Describe in detail the dates, locations and nature of treatment or services rendered by defendant
4. What statements or comments were made to/(by) you or relatives by/(to) the adverse party or parties in connection with the alleged negligence?

LIFE INSURANCE (WRONGFUL DEATH CLAIM ONLY)

Name of your insurance company_____ Policy #_____

Amount of any monies received or to be received_____

PRIOR MEDICAL

Have you ever suffered any other serious illness or personal injuries prior to the date of the occurrence? _____(yes/no)

Have you ever suffered from any medical condition which required hospitalization?_____ (yes/no)

List on a separate sheet all doctors and hospitals (even if done on an outpatient basis) rendering treatment to you during the past ten years. Please be sure to include names, addresses, treatment dates and the nature of the injury or illness (even if unrelated to present complaint).

Are you taking any medications on a routine basis? _____ (yes/no)

If so, please list the name(s) and reason(s) for taking the medication.

If you are taking medications(s) as a result of this incident, please list the name and address of any pharmacy from which you purchased the prescription.

DAMAGES TO DATE

Amount of time off work _____ Loss of income _____

Spouse amount of time off work _____ Loss of income _____

Please provide us with the copies of all doctor and hospital bills/insurance statements which you have received as a result of this occurrence. Also, include any miscellaneous expenses involved.

POINTS TO REMEMBER

Give no information to anyone other than representatives of our office.

Forward to this office all bills or receipts for medical treatment, property damage, loss of earnings, and medical reports.

Please be patient. Your case may take three to six months before a settlement, if any, can be effected. If lawsuit, then longer.

Thank you for your cooperation and assistance with this information.

