PERSONAL INJURY INTAKE FORM

Have You Spoken To Another Attorney About The Case? Yes___No___

If So, Please Give Name Of Attorney: ____________________________________

Do You Have A Singed Release By That Attorney? Yes___No___

Who Were You Referred By: (Individual, Website, Etc.)_________________

DATE OF ACCIDENT:________________________

S.O.L.:________________________

CLIENT INFORMATION:

Client's Name:____

Client's Address:____

____

City: ________________ State:_____ Zip Code:___________

Home Phone: _________________ Cell Phone: ________________

Email Address: ____Age: ______

D.O.B.: ___________SS# ____________________________

Employer: ____

Address: ____

Work Phone: _________________ Ext.:__________

Fax: __________________Work Days/Hours: __________

How long have you worked there? _______

Immediate Supervisor: ____

Spouse's Name: ____

Address:____

City: ______________ State: ____ Zip Code:__________

Home Phone: ______________ Cell Phone: _____________

Employer: ____

Address: ____

Work Phone: _______________ Occupation: _______________________

Client's Employer: ________________ Occupation: ___________________

____

Client's Employer: ________________ Occupation: ___________________

Duties: ____

____

Prior **similar injuries**, treated medical conditions and/or symptoms to same area or current injury (Dates/Drs.):

____

____

____

Prior **claims and/or settlements** (types, dates, attorneys):

____

____

List any **prior injury settlements**:

____

____

ACCIDENT INFORMATION

Date of Accident: __________ Day of Week: _________Time: _____AM/PM

Where: (Be Specific) ____

____

Where were you coming from? ____

Where were you going? ____

DETAILS OF ACCIDENT:

Weather condition (if happened outside): ___________________________________

Any construction in the area? ____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC – GET AS MUCH DETAIL AS POSSIBLE)

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Did this injury occur when you were driving? Yes___No___

Were you driving a company vehicle? Yes___No___

What was the make, model and year of the vehicle you were driving? _______________

____

Was anyone, including yourself, to the best of your knowledge, taking any medications or using any sort of drugs? Yes___No___

If so, please list: ____

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____

Had you or anyone been drinking? Yes___No___

Did anyone make a statement at the scene? Yes___No___

If so, who? What was said?

____

____

To whom? ____

Were photographs taken of the scene? ____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: ____

Address: ____

____

Phone: ____

Agent's Name: ____

Address: ____

____

Phone: ____

Collision coverage amount: ______________________________________

Deductible Amount: ____

Liability Coverage: ____

Medical Payment Amount: ____

Uninsured Motorist Coverage Amount: ______________________________

Cash Policy for Accidents: ______________________________________

Effective Dates of coverage: ______________________________________

Is this a worker's comp claim? ____________________________________

Are you covered through your employer's insurance? Yes___No___

If so, provide company and agent, if known: __________________________

Policy or plan number: ____

Name of insured: ____

Limits of coverage: ____

Did you file a claim with your insurance company? Yes____No____

Has anyone from the insurance company contacted you? Yes___No___

If yes, name of person who contacted you: _______________________________

When was contact made? ____

If a statement was given, was it tape recorded or written? ________________

Did you receive a copy? Yes___No___

Have you signed any authorizations to release information? Yes___No___

If so, identify: ____

Have you signed any releases? Yes___No___

If so, for whom? ____

Have you received any insurance benefits? Yes___No___

Have you been judged by an administrative agency as permanently or partially disabled as the result of this incident? Yes___No___

If so, which agency? ____

INSURANCE COVERAGE FOR DEFENDANT

Name of Carrier: ____

Address: ____

____

Phone: ____

Agent's Name: ____

Address: ____

____

Phone: ____

Collision coverage amount: _____________________________________

Deductible Amount: ____

Liability Coverage: ____

Medical Payment Amount: ____

Uninsured Motorist Coverage Amount: _____________________________

MEDICAL INFORMATION:

Were you injured in this accident? Yes___No___

If so, please describe:

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Did you go to the hospital? Yes___No___

If so, which hospital: ____

Admitted or Outpatient? _____________________

If admitted, release date: ____________________

X-Rays taken? Yes___No___

Were you taken by ambulance? Yes___No___

Are you under the care of a physician now? Yes___No___

Did you miss work due to accident? Yes___No___

LIST DOCTORS:

1. Name: __________________________ Phone: ___________________________

   Address: ____

   ____

   Telephone Number: ________________________________

When did you last see the doctor? ____

When will you see the doctor again? ______________________________________

Physical therapy? Yes___No___

Current Balance on Medical Bills: ____

2. Name: ____________________________ Phone: ___________________________

Address: ____

____

Telephone Number: ________________________________

When did you last see the doctor? ____

When will you see the doctor again? ______________________________________

Physical therapy? Yes___No___

Current Balance on Medical Bills: ____

3. Name: ____________________________ Phone: ___________________________

Address: ____

____

Telephone Number: ________________________________

When did you last see the doctor? ____

When will you see the doctor again? ______________________________________

Physical therapy? Yes___No___

Current Balance on Medical Bills: ____

4. Name: ____________________________ Phone: ___________________________

Address: ____

____

Telephone Number: ________________________________

When did you last see the doctor? ____

When will you see the doctor again? ______________________________________

Physical therapy? Yes___No___

Current Balance on Medical Bills: ____

5. Name: ___________________________ Phone: _________________________

Address: ____

____

Telephone Number: _______________________________

When did you last see the doctor? _______________________________________

When will you see the doctor again? _____________________________________

Physical therapy? Yes___No___

Current Balance on Medical Bills: ____

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING OR WHEN CAST IS REMOVED.

Was anyone else injured? Yes___No____

Who was injured? ____

Describe the injury: ____

____

____

NAME AND ADDRESSES OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

____

____

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WITNESSES:

1. Name and address: ____

   ____

   Telephone Number: (____) ________________________________

   Relationship (fellow employees, supervisors, bystanders, etc.): ______________

   What did each see? ____

   Would they be willing to testify in court to what he/she saw? Yes___No___

2. Name and address: ____

   ____

   Telephone Number: (____) ________________________________

   Relationship (fellow employees, supervisors, bystanders, etc.): ______________

   What did each see? ____

   Would they be willing to testify in court to what he/she saw? Yes___No___

3. Name and address: ____

   ____

   Telephone Number: (____) ________________________________

   Relationship (fellow employees, supervisors, bystanders, etc.): ______________

   What did each see? ____

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   ____

   Telephone Number: (____) ________________________________

   Relationship (fellow employees, supervisors, bystanders, etc.): ______________

What did each see? ____

Would they be willing to testify in court to what he/she saw? Yes___No___

5. Name and address: ____

____

Telephone Number: (____) ______________________________

Relationship (fellow employees, supervisors, bystanders, etc.): _____________

What did each see? ____

Would they be willing to testify in court to what he/she saw? Yes___No___

VIEWING THE SCENE:

Can we go to the accident scene? Yes___No___

Is the equipment available for inspection? Yes___No___

Who do we contact to arrange a viewing? __________________________________

NAME AND ADDRESS: ____

____

Telephone Number: (__) ________________

Job Title: ____

Can we photograph the equipment? Yes___No___

Any other information you feel may assist us in representing you for this claim?

____

____

____

____

____

DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): ____________________________

____

Sports: ____

____

Social Activities: ____

____

Job Duties: ____

____

Household Chores: ____

____

Have you had to hire domestic help? Yes___No___

How do you feel you have been damaged emotionally by these injuries? ___________________

____

How do you feel you have been damaged financially by these injuries? _____________________

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