Client ______________________________ Date filled out __________

Referred by: ____

Client Information Form

This questionnaire is for the use of our office only. Please answer every question fully and accurately. We cannot properly represent or advise you unless we have proper information.

Please type or print all answers. Use additional sheets of paper or reverse side of this form if needed.

Case Information

Date of accident: ____

Other parties involved in accident:

Name	Insurance Company

Insurance Adjusters who have contacted client:

Name	Insurance Company	Telephone

Has workers' compensation been claimed or paid? ____________________

Has medicare been claimed or paid? ______________________________

Client's insurance

A. Automobile: ______________________________

Policy No.: ______________________________

Agent: ______________________________

Address: ______________________________

Telephone: ______________________________

Adjuster: ______________________________

Address: ______________________________

Telephone: ______________________________

B. Health and Accident: ______________________________

Policy No: ______________________________

Agent: ______________________________

Address: ______________________________

Telephone: ______________________________

C. Occupied Vehicle (if different from A)

Policy No: ______________________________

Agent: ______________________________

Address: ______________________________

Telephone: ______________________________

Adjuster: ______________________________

Address: ______________________________

Telephone: ______________________________

Accident Facts

("Client vehicle" is one in which client was riding)

1. Date: ______________________ Time: ______________________
2. Place: ____
3. Description of vehicles:

   Client's vehicle: ______________________________________

   Others: ____

4. Driver's Name:
   Client vehicle: ____

   Address: ____

   Other: ____

   Address: ____

5. Owner's Name:
   Client vehicle: ____

   Address: ____

   Other: ____

   Address: ____

6. Passenger Names:
   Client vehicle: ____

   Address: ____

   Other: ____

   Address: ____

7. Witnesses: ______________________ Address: __________________

   ______________________ __________________

   ______________________ __________________

   ______________________ __________________

8. Driver drinking or disability:

   Client vehicle - Explain: ________________________________

   ____

Other - Explain: ______________________________

____

9. Road Conditions: ______________________________

Weather conditions: ______________________________

10. Road width: ______________ Lanes: ______________

Direction: ______________________________

Posted Speed: ______________________________

11. Traffic controls: ______________________________

____

12. How accident occurred (including speed, direction, etc.: ______________________________

____

13. Position of vehicles after accident:

Client vehicle: ______________________________

Other: ______________________________

14. Location and extent of damage to vehicles:

Client vehicle: ______________________________

Other: ______________________________

15. Location and description of collision debris:

____

16. Skid mark location and length:

Client vehicle: ______________________________

Other: ______________________________

17. Damages to objects other than vehicles:

Description: ______________________________

Which vehicle inflicted?: ______________________________

PROPERTY DAMAGE

1. Your vehicle

Where taken after accident: ______

By whom: ______

Where is vehicle now? ______

If repaired, by whom: ______

Address: ______ Telephone: ______

______ Cost: ______

If total loss, who bought salvage? ______

Address: ______ Price: ______

______

When and where purchased: ______

Price when purchased: ______

If not yet repaired, estimates: ______

______

2. Collision insurance coverage: ______

Deductible: ______

Adjuster, name, address, and phone: ______

______

Status of collision claim: ______

3. Rental of substitute vehicle:

From whom: ______

Rental cost to date and rental rate: ______

Necessity of: ______

Estimated value of loss of use: ______

4. Other involved vehicles

Owner: ______________________ Description: ________________

Address: ____________________ Phone: ____________________

____

Driver: ______________________ Phone: ____________________

Address: ____________________

____

Estimated repair cost: ______________________________________

Where vehicle taken after accident: ____________________________

Insurance company and adjuster: _______________________________

Owner: ______________________ Description: ________________

Address: ____________________ Phone: ____________________

____

Driver: ______________________ Phone: ____________________

Address: ____________________

____

Estimated repair cost: ______________________________________

Where vehicle taken after accident: ____________________________

Insurance company and adjuster: _______________________________

5. Property damage other than vehicular: ______________________

____

Owner name, address, and phone: ____________________________

____

Description and extent of damage: __________________________

____

Estimated repair cost: ______________________________________

STATEMENTS MADE

1. Did client tell any police officer, investigator, insurance adjuster or any other person about the accident (whether at the scene or later)?

____

____

2. Did client give any written statement to any person about the accident: ________ If so answer the following:

a. Name of person to whom statement was given: ______________

____

b. Date given: ____________________________________

c. If written, does client have a copy? ____________________

d. Persons present at time: ____________________________

e. Did client sign the statement? ________________________

3. Please relate any statement the defendant made about the accident, or that you understand he may have made:

____

____

____

4. When and where made: ________________________________

____

5. Name and address of person who heard it: __________________

____

6. Do you know of any other witness who has given a statement about the accident?

____

7. When and where made: ________________________________

8. Name and address of person who heard it: __________________

____

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PERSONAL

Client

Social Security Number: ______________________________

Address: ______________________________

Telephone: (home) ______________ (work) ______________

Date of birth: ______________________

Education and/or special employment training: ______________

____

Military Service: (branch) ______________________________

Dates of military service: ______________________________

Previous claims for personal injuries of property damage:

Date	Against Whom	Nature of Claim	Suit Filed	Result

Health immediately prior to accident: ______________________

Doctor and comment, if under care immediately prior to accident:

____

____

Injuries or diseases requiring hospitalization or treatment by doctor for five-year period prior to accident:

____

1. Nature: ______________________________

   Hospital or Doctor: ______________________________

   Date: ______________________________

2. Nature: ______________________________

   Hospital or Doctor: ______________________________

   Date: ______________________________

Limitations on driver's license: ______________________________

EMPLOYMENT (NOT SELF-EMPLOYED)

Client

I. Immediately before accident:

Employer: ____________________

Address: ____________________

Phone: __________ First employed: __________

Job title or type of work: ____________________

How long on job: __________ Hours: __________

Immediate supervisor: ____________________

Gross earnings: __________ per: __________

Average overtime earnings: __________ per: __________

Earnings for year prior to accident: ____________________

II. As a result of the accident (if you have returned to work):

Inclusive dates unable to work: ____________________

____________________ Total days: __________

Difficulty in performing job when returned: ____________________

Explain: ____________________

____

____

Increase or decrease in pay since accident: ____________________

Explain: ____________________

____

III. If changed employer since accident:

Employer: ______________________________

Address: ______________________________

Telephone: ______________________________

First employed: ______________________________

Job title or type of work: ______________________________

Immediate supervisor: ______________________________

How long on job: ______________ Hours: ______________

Gross Earnings: ______________ per: ______________

IV. Employment for past ten (10) years:

Employer	From-To	Job	Reason for leaving

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EMPLOYMENT (SELF-EMPLOYED)

Client

Business name: ______________________________

Type of Business: ______________________________

Address. ______________________________

Phone: ______________________________

Date Commenced: ______________ Extent of Ownership: ______________

Duties: ______________________________

____

Present salary or draw: ______________ per: ______________

Earnings for 5-year period prior to injury:

Year	Draw	+ Profit	= Gross Income	- Deductions	= Net

Other income (except investments):

Source	Amount

EMPLOYMENT

Spouse

Employer: ____________________

Address: ____________________

Phone: ____________________

Type of Work: ____________________

How long on job: ____________________ Hours: __________

Immediate supervisor: ____________________

Gross earnings: ____________________ per: __________

Dates of loss or work due to client's injuries:

____________________ Total: __________

INJURIES

Client

Describe emergency treatment given at the scene:

___

___

___

___

___

State, in full detail, all injuries received as a result of this accident and when these were first noticed:

___

___

___

___

___

___

___

___

Describe present physical condition--scars, deformities, headaches, pains, etc. due to injuries received in this accident:

___

___

___

___

___

___

___

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MEDICAL

Client

List all hospitals in which client was examined or treated, or to which client was admitted as a patient as a result of the injuries, the dates, and the total costs:

1. Hospital: ____________________

   Address: ____________________

   From: __________ To: __________

   Total Costs: ____________________

2. Hospital: ____________________

   Address: ____________________

   From: __________ To: __________

   Total costs: ____________________

3. Hospital: ____________________

   Address: ____________________

   From: __________ To: __________

   Total costs: ____________________

List the full name, address and telephone number of each physician or surgeon who examined or treated client for injuries resulting from the accident:

1. Doctor's name: ____________________

   Address: ____________________

   Telephone: ____________________

   Type of treatment: ____________________

   Dates: ____________________

2. Doctor's name: ____________________

   Address: ____________________

   Telephone: ____________________

   Type of treatment: ____________________

   Dates: ____________________

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3. Doctor's name: ______________________________

Address: ______________________________

Telephone: ______________________________

Type of treatment: ______________________________

Dates: ______________________________

4. Doctor's name: ______________________________

Address: ______________________________

Telephone: ______________________________

Type of treatment: ______________________________

Dates: ______________________________

5. Doctor's name: ______________________________

Address: ______________________________

Telephone: ______________________________

Type of treatment: ______________________________

Dates: ______________________________

6. Doctor's name: ______________________________

Address: ______________________________

Telephone: ______________________________

Type of treatment: ______________________________

Dates: ______________________________

7. Doctor's name: ______________________________

Address: ______________________________

Telephone: ______________________________

Type of treatment: ______________________________

Dates: ______________________________

DISABILITIES

Client

Indicate if any of the following was used in connection with treatment of client:

		From - To
Back or neck brace ______	Dates:	______
Crutches ______	Dates:	______
Traction ______	Dates:	______
Physiotherapy ______	Dates:	______
Other ______	Dates:	______

List normal activities including sports, hobbies, or other activities enjoyed before this accident:

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List usual activities which client has not been able to perform, or can only perform with difficulty, since the accident, such as climbing stairs, ironing, cutting grass, dancing, lifting children, etc.:

____

____

____

____

____

____

____

____

____

____

How long partially disabled?____________________________

In case of housewife, how long before able to do housework? (Give dates):

____

WITNESS - DAMAGES

List perspective witnesses who have knowledge of client's damages and/or personal, family, and business life:

1. Name: ______________________

   Address: ______________________

   Relationship: ______________________

   Area of Knowledge: ______________________

2. Name: ______________________

   Address: ______________________

   Relationship: ______________________

   Area of Knowledge: ______________________

3. Name: ______________________

   Address: ______________________

   Relationship: ______________________

   Area of Knowledge: ______________________

4. Name: ______________________

   Address: ______________________

   Relationship: ______________________

   Area of Knowledge: ______________________

5. Name: ______________________

   Address: ______________________

   Relationship: ______________________

   Area of Knowledge: ______________________

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SUMMARY OF OUT-OF-POCKET EXPENSES

Client

	Amount	Paid (x)
Physicians and surgeons: ________	________	________
Ambulance: ________	________	________
Hospitals: ________	________	________
Nurses: ________	________	________
Drugs: ________	________	________
Crutches, braces, etc. ________	________	________
X-rays (if not included in hospital bills): ________	________	________
Domestic help: ________	________	________
Auto repair: ________	________	________
Car rental: ________	________	________
Lost wages: ________	________	________
other (explain): ________	________	________
TOTAL	$ ________	________

AS OF (DATE) ________

Are more expenses anticipated?________

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CONCLUSIONS

In completing this questionnaire, have you thought of any information which may possibly be of some assistance to us? If so, please state it, no matter how trivial it might seem to you.

____

____

____

____

____

____

____

____

____

____

____

____

Please furnish a copy of the following:

( ) Income tax returns for the last five (5) years (if checked).

( ) Photographs of client prior to accident.

( ) Copies of all bills associated with the accident (whether paid or not)

( ) Automobile and health insurance policies (if checked).

( ) Itemized bill for repair of vehicle.