

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: _____

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:

<u>Date</u>	<u>Against Whom</u>	<u>Nature of Claim</u>	<u>Suit Filed</u>	<u>Result</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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:

<u>Employer</u>	<u>From-To</u>	<u>Job</u>	<u>Reason for leaving</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

<u>Year</u>	<u>Draw</u>	+	<u>Profit</u>	=	<u>Gross Income</u>	-	<u>Deductions</u>	=	<u>Net</u>
_____	_____		_____		_____		_____		_____
_____	_____		_____		_____		_____		_____
_____	_____		_____		_____		_____		_____
_____	_____		_____		_____		_____		_____
_____	_____		_____		_____		_____		_____

Other income (except investments):

<u>Source</u>	<u>Amount</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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:

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: _____

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: _____

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: _____

SUMMARY OF OUT-OF-POCKET EXPENSES

Client

	<u>Amount</u>	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? _____

