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PERSONAL INJURY CLIENT INTERVIEW FORM

Date: _____ Referral Source: _____

BACKGROUND INFORMATION

Full Name: _____
First Middle Last
Other names known by (including maiden name):_____
Street/Mailing Address: _____
City, State, Zip: _____
Telephone: Home _____ Cell _____ Other _____
Email Address: _____
List the home addresses you have had for the past five year, including the dates of such addresses:_____
Any other additional addresses where mail can be forwarded to you:_____
Any telephone not listed above: _____

Date of Birth: _____ Place of Birth: _____
Age: _____ Weight: _____ Height: _____
Social Security No.: _____-_____-_____ Driver's License No.: _____
Marital Status (Check One): _____ Married _____ Single _____ Divorced
_____ Separated _____ Widowed/Widower
Spouse's Name: _____
First Middle Last Date of Birth

Children:

_____
Name Address/phone Date of Birth

_____
Name Address/phone Date of Birth

_____
Name Address/phone Date of Birth

OCCUPATION

Employer: _____
Address: _____
Job Title: _____ How long employed? _____
Name of Supervisor: _____ Telephone: _____
Your last date worked before illness or injury: _____
Rate of Pay: _____ Per: Month _____ Week _____ Bimonthly _____
Date returned to work: _____

If your job changed after illness or injury, indicate new job or duties and reason for change. _____

_____

Names and addresses of previous employers for past five years. (Please state dates of employment, type of work, and reasons for leaving.)

_____

_____

Name and address of spouse's current employer and how long employed.

_____

_____

Do you have available for the past five years your income tax records showing your earnings for those years? _____ If yes, please provide copies to our office.

INCIDENT INFORMATION

Date of Injury: _____ Time: _____ SOL: _____
Location: _____ County: _____
Weather Conditions: _____
Status: (e.g., driver, passenger, pedestrian); If passenger, who is driver? _____

_____

Were police called? Yes _____ No _____ Agency: _____
Was fire department called? Yes _____ No _____ Agency: _____
Was ambulance called? Yes _____ No _____ Agency: _____
List any citations given and to whom: _____

Describe what happened: _____

_____

_____

_____

_____

_____

_____

Draw a diagram of accident scene:

INSURANCE INFORMATION

Your Health Insurance Company: _____
Address: _____
Policyholder: _____ ID/Policy Number: _____

OTHER PARTY INFORMATION

Other Party
Name: _____
Address: _____
City, State, Zip: _____
Driver's License No.: _____
Insurance Company: _____ Adjuster Name: _____
Policy Number: _____ Claim Number: _____
Policy Limits: _____ Recorded statement given? Yes _____ No _____

***For additional defendants, use the back of this form.**

WITNESS INFORMATION

Names of any witnesses: (Please include addresses and telephone numbers, if known.)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

INJURIES/MEDICAL TREATMENT

Did you authorize or send medical reports to anyone relating to this accident? If so, please give names, addresses, and date authorization was sent. _____

Did you make any statements to anyone concerning this accident? If so, please state to whom, date, circumstances, and if you made or signed any written statements.

List all INJURIES that you received as a result of this accident. _____

List the names of every HOSPITAL you have been seen at since the accident occurred whether or not you were treated for injuries caused by the accident. Include dates and reasons for each hospitalization.

Date of Admission	Hospital	Reason
Date of Admission	Hospital	Reason
Date of Admission	Hospital	Reason

List the names and addresses of all DOCTORS who have treated you for your injuries.

List the names and addresses of all PHYSICAL THERAPISTS who have treated you for your injuries.

Describe every past injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.)

List all illnesses or injuries for which you were being treated at the time of the accident.

When is your next doctor's appointment?

Dr. Name: _____ Date: _____

Location: _____

List the names and addresses of all doctors you saw in the past ten years before the accident. (Please include the reason you saw them and what treatment they prescribed, if any.)

List all illnesses or injuries for which you were being treated at the time the accident occurred.

List the name of every hospital you were in during the ten-year period before the accident occurred. (List the dates and reasons for each hospitalization.)

List every surgical operation performed since the accident occurred.

PROBLEMS RELATED TO ACCIDENT

List every illness or injury which you believe was caused or made worse by the accident.

_____

_____

List and describe all other expenses due in any way to the accident.

$_____

$_____

$_____

$_____

$_____

$_____

ADDITIONAL BACKGROUND INFORMATION

List every injury or illness not already mentioned that you have ever had for which you saw a doctor, and the approximate year in which each occurred.

_____

_____

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons, and results.

_____

_____

_____

_____

_____

_____

Have you ever been arrested? Yes _____ No _____
If yes, please provide the following information:
Date: _____ Charge:_____
Result _____

Have you ever been convicted of a crime? Yes____ No____
If yes, please provide the following information:
Date: _____Charge:_____
Date: _____Charge:_____
Result (fine, penalty, etc.):_____

_____

_____

Have you ever filed bankruptcy? Yes _____ No _____
If yes, please provide the following information:
Date: _____Location:_____

Have you ever been represented by another attorney? Yes _____ No_____
Name:_____
Address:_____
Reason:_____

Give any other information you feel we should have to represent you effectively in this case _____
_____
_____
_____

Give the names and addresses of two people who will always know where to reach you.
_____
_____

Please give a brief summary of what you think a fair outcome would be in your case.
_____
_____
_____
_____

All items below are needed to complete your personal injury file, if they apply to your case. Bring in originals, or copies as soon as possible.

Items needed:

[ ] Tax returns with schedules and W-2s - last two years
[ ] Paycheck stubs from last two months
[ ] No-Fault Proof of Insurance
[ ] Health Insurance card
[ ] Health Insurance Policy
[ ] Disability Insurance policies - short or long term
[ ] Medical bills from all doctors or hospitals
[ ] Explanation of benefits from all insurance companies