# THOMPSON, THOMPSON & GLANVILLE, PLC

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## PERSONAL INJURY INITIAL CLIENT INTERVIEW (AUTO)

Date: _____ Referral Source: _____

| BACKGROUND INFORMATION | | | |
|---|---|---|---|
| Full Name (First, Middle, Last): | | | |
| Other names known by (including maiden name): | | | |
| Street Address: | | | |
| City, State, Zip: | | | |
| Cell Phone #: | | Other Phone #: | |
| Email Address: | | | |
| Date of Birth: _____/_____/_____ | Soc Sec No: _____-____-_____ | Driver's License No: _____ | |
| Marital Status (Check One): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed/Widower | | | |
| Spouse's Full Name (First, Middle, Last): | | | |

| OCCUPATION | | | |
|---|---|---|---|
| Employer Name: | | | |
| Address: | | | |
| Occupation: | | Position: | |
| Start Date: | | End Date: | |
| Name of Supervisor: | | Telephone: | |
| Your last date worked before illness or injury: | | | |
| Rate of Pay Per: | Month $_____ | Week $_____ | Bimonthly $_____ |
| Date returned to work: | | | |

| INCIDENT INFORMATION | | | |
|---|---|---|---|
| Date of Injury: | | Time: | SOL: |
| Location of Incident: | | | County: |
| Weather Conditions: | | Road conditions on the date of the incident? | |
| Were you a (check one): ☐ driver ☐ passenger ☐ pedestrian ☐ cyclist. If passenger, who is driver _____ | | | |
| Was the incident reported to the police? ☐ Yes ☐ No Agency: _____ | | | |

| | |
|---|---|
| Does the client have a copy of the police report? If so, please provide a copy. ☐ Yes ☐ No | |
| Was fire department called? ☐ Yes ☐ No Agency: _____ | |
| Was ambulance called? ☐ Yes ☐ No Agency: _____ | |
| Were you taken by ambulance? ☐ Yes ☐ No | List any citations given and to whom: |
| Describe what happened: | |
| Draw a diagram of accident scene: | |

| INSURANCE INFORMATION | | | | |
|---|---|---|---|---|
| Vehicle Information: | Year: | Make: | Model: | Plate #: |
| Describe damage to your vehicle: | | | | |
| Was the vehicle towed? ☐ Yes ☐ No | | Location of your vehicle: | | |
| Property Damaged? ☐ Yes ☐ No Describe: _____ | | | Property damage resolved? ☐ Yes ☐ No | |
| Were photos taken? ☐ Yes ☐ No | | Location of photos: | | |
| **Vehicle in Which You Were Driver/Passenger at time of Accident** | | | | |
| Auto Insurance Company: | | | | |
| Address: | | | | |
| Policyholder/Insured (If Not You): | | | | |
| Policy Number: | | Claim Number: | | |
| Adjuster Name: | | | Phone Number: | |
| Policy Limits: | | | PIP application completed? ☐ Yes ☐ No | |
| **Your Vehicle (If Different) or Vehicle on which you are named Insured or Household Member** | | | | |
| Auto Insurance Company: | | | | |
| Address: | | | | |
| Policyholder/Insured (If Not You): | | | | |
| Policy Number: | | Claim Number: | | |
| Adjuster Name: | | | Phone Number: | |
| Policy Limits: | | | PIP application completed? ☐ Yes ☐ No | |
| **Were You On the Job at the Time of the Accident? ☐ Yes ☐ No** | | | | |
| Workers' Compensation Insurance Company: | | | | |
| Address: | | | | |
| Insured: | | | Claim Number: | |
| Adjuster Name: | | | Phone Number: | |

| Health Insurance Details: | | | |
|---|---|---|---|
| Do you presently have health insurance? ☐ Yes ☐ No | | Have you ever had Medicaid/Medicare? ☐ Yes ☐ No | |
| Name of your Health Insurance Company: | | | |
| Address: | | | |
| Policyholder: | | ID/Policy Number: | |
| Did you receive any Insurance benefits? ☐ Yes ☐ No | | Have you ever been denied health insurance? ☐ Yes ☐ No | |

| OTHER PARTY INFORMATION | | | |
|---|---|---|---|
| **Other Party #1** | | | |
| Name: | | | |
| Address: | | City, State, Zip: | |
| Date of Birth: | | Driver's License No.: | |
| Vehicle (Year/Make/Model): | | Plate Number: | |
| Insurance Company: | | Adjuster Name: | |
| Policy Number: | | Claim Number: | |
| Policy Limits: | | Recorded statement given? ☐ Yes ☐ No | |
| **Other Party #2** | | | |
| Name: | | | |
| Address: | | City, State, Zip: | |
| Date of Birth: | | Driver's License No.: | |
| Vehicle (Year/Make/Model): | | Plate Number: | |
| 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<br>Names of any witnesses: (Please include addresses and telephone numbers, if known.) | | | |
|---|---|---|---|
| Witness #1 Name: | | Phone: | |
| Address: | | | |
| Witness #2 Name: | | Phone: | |
| Address: | | | |
| Witness #3 Name: | | Phone: | |
| Address: | | | |
| Witness #4 Name: | | Phone: | |
| Address: | | | |

## INJURIES/MEDICAL TREATMENT

**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 all DOCTORS who have treated you for your injuries.**

| Name | Phone Number | Address |
|---|---|---|
| Name | Phone Number | Address |
| Name | Phone Number | Address |
| Name | Phone Number | Address |

**List all PHYSICAL THERAPISTS who have treated you for your injuries.**

| Name | Phone Number | Address |
|---|---|---|
| Name | Phone Number | Address |
| Name | Phone Number | Address |

**Describe every past injury, accident, including work-related accidents, in which you have ever been involved**.

| Date/Time | Location | Type of Accident | Injuries |
|---|---|---|---|
| Date/Time | Location | Type of Accident | Injuries |
| Date/Time | Location | Type of Accident | Injuries |

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

## ADDITIONAL BACKGROUND INFORMATION

**List every claim or lawsuit in which you have been involved in any way.**

| Approximate Year | Names of Parties Involved | Reason | Results |
|---|---|---|---|
| Approximate Year | Names of Parties Involved | Reason | Results |
| Approximate Year | Names of Parties Involved | Reason | Results |

**Have you ever been arrested? ☐ Yes ☐ No If yes, please provide the following information:**

| | |
|---|---|
| Date: | Charge: |
| Date: | Charge: |
| Date: | Charge: |

**Have you ever been convicted of a crime? Yes No If yes, please provide the following information**:

| | | |
|---|---|---|
| Date: | Charge: | Result (fine, penalty, etc.): |
| Date: | Charge: | Result (fine, penalty, etc.): |
| Date: | Charge: | Result (fine, penalty, etc.): |
| Date: | Charge: | Result (fine, penalty, etc.): |

**Have you ever filed bankruptcy? ☐ Yes ☐ No If yes, please provide the following information:**

| | | |
|---|---|---|
| Date: | Location: | Attorney Who Represented You |

**Have you ever been represented by another attorney? Yes No**

| | | |
|---|---|---|
| Name: | Address: | Reason: |
| Name: | Address: | Reason: |
| Name: | Address: | Reason: |

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

| 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.

☐ 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