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PERSONAL INJURY CLIENT INTERVIEW FORM (NON 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: _____
Place of Birth:	Age:	Weight: _____ Height: _____
Marital Status (Check One): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed/Widower		
Spouse's Full Name and Date of Birth::		
List the home addresses you have had for the past five year, including the dates of such addresses:		

CHILDREN	
Child #1:	
Full Name (First, Middle, Last):	
Date of Birth:	
Street Address:	
City, State, Zip:	
Child #2:	
Full Name (First, Middle, Last):	
Date of Birth:	
Street Address:	
City, State, Zip:	
Child #3:	
Full Name (First, Middle, Last):	
Date of Birth:	
Street Address:	
City, State, Zip:	
ATTACH ADDITIONAL SHEETS IF NECESSARY.	

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:			
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? ☐ Yes ☐ No If yes, please provide copies to our office.			

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

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

Name:			
Address:		City, State, Zip:	
Date of Birth:		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.)

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.

Did you authorize or send medical reports to anyone relating to this accident? ☐ Yes ☐ No If so, please give names, addresses, and date authorization was sent.

Did you make any statements to anyone concerning this accident? ☐ Yes ☐ No If so, please state to whom, date, circumstances, and if you made or signed any written statements.

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

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

Type of expense:		Cost Incurred:	$
Type of expense:		Cost Incurred:	$
Type of expense:		Cost Incurred:	$
Type of expense:		Cost Incurred:	$
Type of expense:		Cost Incurred:	$

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.

Approximate Year	Doctor	Reason	Results
Approximate Year	Doctor	Reason	Results

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

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.

☐ 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