PERSONAL INJURY CLIENT QUESTIONNAIRE

Date of Initial Consultation: ___________________
Client Referred by: _____________________________

DATE OF ACCIDENT: ______________________

DEFENDANTS: 1) _____________________ 2) ________________________

Is any Defendant a Municipality, such as CTA, PACE, or METRA? Yes / No

TYPE OF ACCIDENT (circle): Car Accident Slip and Fall Dog Bite Product Liability

Was a police report or incident report made? Yes / No
Is this report in your possession? Yes / No
Police Agency (ie. Barrington P.D., Lake County Sherrif) _________________________
Police Report # (Typically located in the upper right-hand corner) _______________________

CLIENT'S NAME: ______________________

Address: ____

Home Telephone Number: _________________________________

Alternate Contact Number: _________________________

E-Mail:______________________________

Date of Birth: __________________

Last Four Digits of Your Social Security Number: XXX-XX-__________

Marital Status: Single / Married

Spouse: _________________________________

Spouse's Contact Number (in case of emergency): ___________________________

Were any minor children injured in this incident? Yes No

If yes, who? ____

Name of Current Employer: ________________________________

Approximate yearly salary: _________________________

Start Date with Employer: _________________________

Estimated Wage Loss Due to Injury: ______________________________

ACCIDENT

Date of Accident: ____________________

Time of Day When Accident Occurred: ________________

Location: ____

Weather Conditions: ___________________________

Were there Passengers in any of the Involved Vehicles (if applicable)? Yes No

If Yes, Please Provide Name and Contact Number:

1) ____
2) ____
3) ____

Were there any other Witnesses? Yes No

If Yes, Please Provide Name and Contact Number:

1) ____
2) ____

Did you give any statements to anyone, including any insurance company? Yes No

If Yes, to Whom? ________________________

What was said?: ____

____

Any Pictures Taken of Scene/Property/Injuries? Yes No

Who has Possession of the Pictures? _______________________________

Have you been contacted by the Defendant's Insurance Company? Yes No

Which Insurance Company? ________________________________

Did they provide a Claim Number? Yes No

If Yes, Please Provide the Claim Number: __________________________

Who is your Automobile Insurance Carrier? ___________________________________

What are your Underinsured/Uninsured Coverage Policy Limits? ______________________

Do you have Med Pay Coverage on your policy? _______________________________

If yes, how much is your Med Pay policy limit? ________________________________

Description of Accident (Be very specific):

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____

____

____

____

____

If possible, please diagram:

INJURIES

Client's Initial Injuries (Be very specific): ____

____

____

____

____

Client's Treatment (including ambulance, ER, hospitals, therapy, and physicians):

1. Name of Provider: ______________________________________

   Address: ____

   Telephone Number: __________________________

   Date(s) of Treatment: _____________________

   Future Appointments? ______________________

   Bill: $____________________

2. Name of Provider: ______________________________________

   Address: ____

   Telephone Number: __________________________

   Date(s) of Treatment: _____________________

   Future Appointments? ______________________

   Bill: $____________________

3. Name of Provider: ______________________________________

   Address: ____

   Telephone Number: __________________________

   Date(s) of Treatment: _____________________

   Future Appointments? ______________________

   Bill: $____________________

4. Name of Provider: ______________________________________

   Address: ____

   Telephone Number: __________________________

   Date(s) of Treatment: _____________________

   Future Appointments? ______________________

   Bill: $____________________

Is there any reason that you feel that there may be a question as to whether your injuries were a result of this accident? ____

____

____

PAST MEDICAL AND LITIGATION HISTORY

Has the client ever been in a previous accident? Yes No

If Yes, Please List: ____

____

Has the client suffered from a past serious illness or injury? Yes No

If Yes, please list: ____

____

Has the client been hospitalized in the last 10 years? Yes No

If Yes, please list: ____

____

Have you ever filed a claim or lawsuit for personal injuries or workers comp before? Yes No

If Yes, please list the subject matter, parties involved, court number, court location, settlement amount: ____

____

____

Who is your Health Insurance Carrier? ______________________________________

Policy Number? ___________________________________

Is this Health Insurance Plan provided by your Employer? Yes No

Are you enrolled in Medicare or Medicaid? Yes No

CURRENT LIST OF MEDICAL BILLS:

Ambulance ____ $________________

Hospital ____ $________________

Hospital ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Physical Therapy____ $________________

X-rays (Taken where?)____ $________________

Drugs/Prescriptions____ $________________

Medical Equipment ____ $________________

Property Damage ____ $________________

Other $__________________

Total Bills to Date: $__________________

NOTE: Moving forward, please continue to provide us with all medical records/bills or other pertinent documents connected to the accident.

Thank you for taking the time to complete this form.

We look forward to working with you!