PERSONAL INJURY CLIENT QUESTIONNAIRE

Date of Initial Consultation: ___________________
Client Referred by: ___________________

CLIENT INFORMATION

Lawyer must Log Stat of Limit Date in Computer if case is accepted.
(2 yrs most P.I. cases and 1 yr on Municipality and C.T.A.) Date: _____________ ___ Logged
Name:

Street Address: ____City:

State: __________________ Zip Code: ____________________Home Telephone Number:

Date of Birth: _____/_____/_____ Social Security Number: ________-________-________

Marital Status: ______ Single ______ Married ______ Divorced ______ Widowed

Spouse's Name, if applicable: ____

Children's Names and Dates of Birth, if applicable:

-

EMPLOYMENT HISTORY

Name of Current Employer:

Street Address:

City: ____ State: _____________ Zip Code:

Telephone Number: ______________________ Facsimile Number: ______________________

Occupation (job title): ____

Job Responsibilities:

Length of time employed by current employer:

Amount of Time Loss Since Injury: ____

Pay periods are (check one): ________ Weekly ________ Bimonthly ________ Monthly

Gross income per pay period: _______________ Net income per pay period: _____________

Amount of Wage Loss Since Injury, if known: ____

FORMER EMPLOYERS WITHIN THE LAST 10 YEARS - (START WITH MOST RECENT AND WORK BACK)

1. Name of Previous Employer: ____

Street Address: ____

City: ____________________________ State: ________ Zip Code: ____________

Telephone Number: ___________________ Facsimile Number: ___________________

Occupation (job title): ____

Job Responsibilities: ____
____

Dates Started and Ended Employment with previous employer: _______________________

2. Name of Previous Employer: ____

Street Address: ____City:
State: ________ Zip Code: _____________

Telephone Number: ___________________ Facsimile Number: ___________________

Occupation (job title): ____

Job Responsibilities: ____
____

Dates Started and Ended Employment with previous employer: _______________________

3. Name of Previous Employer: ____

Street Address: ____
City: ____________________________ State: ________ Zip Code: ___________

Telephone Number: ___________________ Facsimile Number: ___________________

Occupation (job title): ____

Job Responsibilities: ____

____

Dates Started and Ended Employment with previous employer: ____________________________

If not employed:

Name of last employer: ____

______Occupation (job title): ____

Dates of employment: ____

Amount of income received from employment during the last year employed: _________

Other sources of income besides income from chief employment:

From whom such income is received: ____

Gross amount: ______________________ Net amount: ________________________

ACCIDENT

Date of Accident: _____________________________ Day: ______________ Time: ______

Location:

Weather Conditions: ____

Name(s) and Address(es) of other Driver(s) Involved, (if applicable):

Passengers In Any of the Involved Vehicles (if applicable)? _____ Yes _____ No

If Yes, Please List: ____

____

Did the Client Give Any Statements To Anyone? _____ Yes _____ No

If Yes, Please List: ____

____

Were any reports made? _____ Yes _____ No

If Yes, Please List: ____

____

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

If Yes, Please List: ____

____

Description of Accident (Be very specific):

-

Are there any statements, notes, medical records, or any other information that is known to be inconsistent or contradicting the facts as described above of the case? If so, Please List: ____
____
____
__

Names and Addresses of Any Witnesses, if known:

1. Name: ____
   Street Address: ____
   City: __________________________ State: ________ Zip Code: _______
   Telephone Number: ____

2. Name: ____
   Street Address: ____
   City: __________________________ State: ________ Zip Code: _______
   Telephone Number: ____

3. Name: ____
   Street Address: ____
   City: __________________________ State: ________ Zip Code: _______
   Telephone Number: ____

INJURIES

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

____

____

____

____

Client's Present Condition:

____

____

____

Client's Treatment (including emergency treatment, hospitals, therapy, and physicians):

1. Name of Provider: ____

   Street Address: ____

   City: ______________________________ State: _________ Zip Code: ________

   Telephone Number: ___________________ Facsimile Number: ___________________

   Physician's Specialty: ____

   Dates of Treatment: __________________________ Amount of Bill: ____________

   Treatment Provided: ____

   ____

   Medications Prescribed: ____

2. Name of Provider: ____

   Street Address: ____

   City: ______________________________ State: _________ Zip Code: ________

   Telephone Number: ___________________ Facsimile Number: ___________________

   Physician's Specialty: ____

   Dates of Treatment: __________________________ Amount of Bill: ____________

   Treatment Provided: ____

   ____

   Medications Prescribed: ____

3. Name of Provider: ____

Street Address: ____

City: ________________________ State: _______ Zip Code: ______

Telephone Number: _______________ Facsimile Number: _______________

Physician's Specialty: ____

Dates of Treatment: _____________________ Amount of Bill: __________

Treatment Provided: ____

____

Medications Prescribed: ____

4. Name of Provider: ____

Street Address: ____

City: ________________________ State: _______ Zip Code: ______

Telephone Number: _______________ Facsimile Number: _______________

Physician's Specialty:

Dates of Treatment: _____________________ Amount of Bill: __________

Treatment Provided: ____

____

Medications Prescribed: ____

Is there any reason that you feel that there may be a question from the opposition as to the causal connection between the treatment provided and your injuries as a result of this accident? If so, Please List:____

____

____

____

_

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 ever been hospitalized? _____ Yes _____ No

If Yes, Please List: ____

____

____

Has the client visited a doctor for any ailment or injury in the past year? _____ Yes _____ No

If Yes, Please List: ____

____

____

Has the client ever made a claim against an insurance company for an injury? ____ Yes ___ No

If Yes, Please List: ____

____

____

Has the client ever been involved in a lawsuit before? _____ Yes _____ No

If Yes, Please List Subject Matter, Parties Involved, Court Number, Court Location, Disposition, etc...: ____

____

____

Have you ever been convicted of a felony or a crime involving dishonesty? ______ Yes ______ No

If Yes, Please List Subject Matter, Parties Involved, Court Number, Court Location, Disposition, etc...: ____

____

____

Medical Bills or Expenses that you have to date.

NOTE: If you have any medical bills or any other regarding the accident , please mail those bills and other information to our office to be put in your file. If you receive medical bills in the future or any other information, please mail it bills to our office.

Doctor ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Doctor ____ $________________

Hospital ____ $________________

Hospital ____ $________________

Hospital ____ $________________

Physical Therapy______________________________________ $________________

Physical Therapy______________________________________ $________________

X-rays (Taken where?)__________________________________ $________________

X-rays (Taken where?)__________________________________ $________________

Ambulance ____ $________________

Drugs/Prescriptions____________________________________ $________________

Medical Equipment ____________________________________ $________________

Property Damage _____________________________________ $________________

Other ____ $________________

Total Bills to Date: $________________

Please provide updated information to Us as to any of the matters contained herein.