PERSONAL INJURY/AUTO ACCIDENT
INTAKE SHEET

INITIAL CLIENT STATEMENT

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE?______________________________

IF SO, PLEASE GIVE NAME OF ATTORNEY: ____

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? ____________________________________

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)

____

PERSONAL INFORMATION:

NAME: ____

Address: ____

Telephone Number: (home) ____

Age: ___ Date of Birth: _____ Social Security No: ___________________________________

EMPLOYER: ____

Address: ____

Telephone Number: (work)____

Occupation: __________ Worked there how long?___________________________________

Immediate Supervisor: ____

SPOUSE'S NAME: ____

Address: ____

Telephone Number: (home) ____

Spouse's Employer: ____

Employer's Address: ____

Telephone Number: (work)________ Occupation: ____________________________________

Age: ___ Date of Birth: _____ Social Security No: ____

CHILDREN:

Name(s)/Age(s): ____

____

____

How many children are living with you now? ____

EMERGENCY CONTACT:

Name: ____

Relationship: ____

Address: ____

City: __________ State: ________ Zip: ____

Telephone Number: ____

EDUCATION:

High School/G.E.D.: _______ Year of Graduation: ____

Technical School: ____

College/University: _______Years & Degree: ____

EMPLOYMENT HISTORY:

Employer: ___________ Position: ____

Duties: ____

____

Employer: ___________ Position: ____

Duties: ____

____

Employer: ___________ Position: ____

Duties: ____

____

Employer: ___________ Position: ____

Duties: ____

____

Prior **similar injuries**, treated medical conditions and/or symptoms

to same area or current injury (Dates/Drs.): ___________________________________

____

____

____

____

Prior **claims and/or settlements** (types, dates, attorneys):

____

____

List any **prior injury settlements**: ____

____

____

ACCIDENT INFORMATION:

Accident Date: __________ Date of Week: ____

Time: __________ am/pm

Location: (Be Specific)____

____

Where were you coming from? ____

Where were you going? ____

DETAILS OF ACCIDENT:

Weather condition (if happened outside): ____

Any construction in the area? ____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC-- GET AS MUCH DETAIL AS POSSIBLE)_______________

____

____

____

____

(Description of accident continued)

____

____

____

____

____

Did this injury occur when you were driving a vehicle?____

Were you driving a company vehicle?____

What was the make, model and year of the vehicle you were driving?_____________________________

____

What was the make, model and year of the other vehicle?____________________________________

____

Was anyone, including yourself, to the best of your knowledge, taking any medication or using any sort of drugs? _____

____

Had anyone, including yourself, been drinking?____

Did anyone make a statement at the scene?____

Who made such a statement, if any?____

What was said?____

____

____

To whom?____

Were photographs taken of the scene?____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: ____

Carrier's Address: ____

Policy Number: ____

Agent's Name, Address and Phone No.: ____

____

Collision coverage amount: ____

Deductible Amount: ____

Liability Coverage: ____

Medical Payment Amount: ____

Uninsured Motorist Coverage Amount: ____

Cash Policy for Accidents: ____

Effective Dates of coverage: ____

Is this a WORKER'S COMP CLAIM? ____

Are you covered through your employer's insurance? __________________________________

If so, provide company and agent, if known: ____

Policy or plan number: ____

Name of insured: ____

Limits of coverage: ____

Did you file a claim with your insurance company? ______________________________

Has anyone from the insurance company contacted you about this claim? ____________________

Name of Person who contacted you: ______________________________

When was contact made? ____

If a statement was given, was it tape recorded or written?

____

Did you receive a copy? ____

Have you signed any authorizations to release information to anyone? ____________________

If so, identify: ____

Have you signed any releases? ____

If so, for whom? ____

Have you received any insurance benefits? ______________________________

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? _____

If so, which agency? ____

<u>INSURANCE COVERAGE FOR DEFENDANT</u>:

Name of Carrier: ____

Carrier's Address: ____

Policy Number: ____

Agent's Name, Address and Phone No.: ______________________________

____

Collision coverage amount: ____

Deductible Amount: ____

Liability Coverage: ____

Medical Payment Amount: ____

Uninsured Motorist Coverage Amount: ____________________________________

MEDICAL INFORMATION:

Were you injured in this accident? ___ Describe: ______________________________

____

____

____

Did you go to the hospital? ____

Which hospital ____

Admitted or Out Patient? ____

If admitted, release date: ____

X-Rays taken? _____ Were you taken by ambulance? ___________________________

Are you under the care of a physician now? ___________________________________

LIST DOCTORS:

1. Name: _____________ Phone: ____________________________________

   Address: ____

   ____

   Telephone Number: ____

   When did you last see the doctor? ______________________________

   When will you see the doctor again? ____________________________

   Physical therapy? ____

   Current Balance on Medical Bills: _______________________________

2. Name: _____________ Phone: ____________________________________

   Address: ____

   ____

Telephone Number: ____

When did you last see the doctor? ____

When will you see the doctor again? ____

Physical therapy? ____

Current Balance on Medical Bills: ____

3. Name: __________ Phone: ______________________________

Address: ____

____

Telephone Number: ____

When did you last see the doctor? ____

When will you see the doctor again? ____

Physical therapy? ____

Current Balance on Medical Bills: ____

4. Name: __________ Phone: ______________________________

Address: ____

____

Telephone Number: ____

When did you last see the doctor? ____

When will you see the doctor again? ____

Physical therapy? ____

Current Balance on Medical Bills: ____

5. Name: __________ Phone: ______________________________

Address: ____

____

Telephone Number: ____

When did you last see the doctor? ____

When will you see the doctor again? ______________________________

Physical therapy? ______________________________

Current Balance on Medical Bills: ______________________________

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR, CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING, OR WHEN CAST IS REMOVED.

Was anyone else injured? ______________________________

Who was injured? ______________________________

Describe Injury: ______________________________

____

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

____

____

____

____

____

____

____

____

____

WITNESSES:

1. NAME & ADDRESS: ______________________________

____

____

Telephone Number: (___)____

Relationship (fellow employees, supervisors, bystanders, etc.):

____

What did each see? ____

Would they be willing to testify in court to what he/she saw? ______________________________

2. NAME & ADDRESS :____

____

____

Telephone Number: (___)____

Relationship (fellow employees, supervisors, bystanders, etc.):

____

What did each see? ____

Would they be willing to testify in court to what he/she saw? ______________________________

3. NAME & ADDRESS: ____

____

____

Telephone Number: (___)____

Relationship (fellow employees, supervisors, bystanders, etc.):

____

What did each see? ____

Would they be willing to testify in court to what he/she saw? ______________________________

4. NAME & ADDRESS: ____

____

____

Telephone Number: (___)____

Relationship (fellow employees, supervisors, bystanders, etc.):

____

What did each see? ____

Would they be willing to testify in court to what he/she saw? ______________________

5. NAME & ADDRESS: ____

____

____

Telephone Number: (___)____

Relationship (fellow employees, supervisors, bystanders, etc.):

____

What did each see? ____

Would they be willing to testify in court to what he/she saw? ______________________

VIEWING THE SCENE:

Can we go to the accident scene? ____

Is the equipment available for inspection? ______________________________________

Who do we contact to arrange a viewing? ______________________________________

NAME & ADDRESS: ____

____

Telephone Number: (___)____

Job Title: ____

Can we photograph the equipment? ____

Any other information you feel may assist us in representing you for this claim? ________________________________

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DIAGRAM OF HOW ACCIDENT OCCURRED:

DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): ______________________________

____

Sports: ______________________________

____

Social Activities: ______________________________

____

____

Job Duties: ______________________________

____

Household Chores: ______________________________

____

Have you had to hire domestic help? ______________________________

How do you feel you have been damaged emotionally by these injuries? ______________________________

____

____

How do you feel you have been damaged financially by these injuries? ______________________________

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____