PERSONAL INJURY QUESTIONNAIRE

This is a CONFIDENTIAL questionnaire for the use of this office only in preparing your claim for personal injuries. Please answer every question fully, honestly, and accurately because, as your attorneys, the more we know about you and your case, the better we will be able to represent you. All of the questions are important even though they may not appear to have anything to do with your case. **Please print.** Use back of form for additional space. **Detach first page and leave with interviewer, if full questionnaire is not complete.**

PERSONAL INFORMATION

Your name _____ _____
First Middle Last

Your address _____
Street City, State Zip

Your date of birth _____/_____/_____ Social Security # ____ - ____ - _____ Drivers License No. _____

Marital Status_____ Spouse=s name, if married_____ _____

Your phone numbers: Home #:_____ Work # _____ Cell #:_____

Your email address: _____

Name & phone # of nearest relative not living with you ?_____

Relationship to you?_____

Do you have Medicaid? _____ Medicare? _____ If so, ID Number_____

ACCIDENT INFORMATION

When you were injured, were you ( ) the driver of a vehicle, ( ) a passenger in a vehicle ( ) on a motorcycle ( ) a pedestrian, or did you ( ) slip and fall?

Name of driver who caused the accident_____ Phone #:_____

Address of other driver:_____

Any other important information regarding the defendant or his/her actions:_____

_____

Date of Accident: _____ Time:_____ am/pm What was the posted speed limit?_____

Describe the weather and road conditions: _____

Where did the accident occur? _____

Describe how the accident happened.
_____

_____

_____

Which police department sent officers, if any? _____ Report No. _____

List the following information for any passengers in your car:

Name	Address	Phone	Relationship	Age
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you have photos of the accident scene? ( ) Yes ( ) No If so, **please provide us with copies.**

Draw a diagram of the accident. Include street labels and directions of travel. (This does not have to be a work of art.)

STATEMENTS MADE

Have you told any police officer, investigator, insurance adjuster, or any other person about the accident?

If so, what did you say and to whom?_____

_____

INSURANCE INFORMATION

Your Auto Insurance Information

What insurance company insured the car you were in?_____

Has that insurance company been notified of the accident and told that you were injured? Yes ( ) No ( )

Adjuster's name_____ Claim number _____

Adjuster's phone number: _____

Have you received forms from your insurance company to fill out for benefits? ( ) Yes ( ) No

If so, **please provide us with a copy.**

Defendant's Auto Insurance Information

(Defendant is the driver who caused the accident.)

Defendant's auto insurance company: _____

Name of insured: _____ Policy #: _____ Claim #: _____

Adjuster's name_____ Claim number _____

Adjuster's phone number: _____

OTHER INSURANCE INFORMATION

Besides auto coverage, list any other health, medical, and/or dental insurance in force at the time of the accident.

_____

_____

Please provide us with a copy of your health insurance identification card.

VEHICLE INFORMATION

Your vehicle

Year: _____Make:_____ Model: _____

Was there any prior damage to your vehicle? ( ) Yes ( ) No If so, where?_____

Was your vehicle drivable after the accident? _____ Where is your vehicle now? _____

Have you obtained an estimate of the damage to your vehicle? ( ) Yes ( ) If so, **please provide copies.**

Do you have photos of your damaged vehicle? ( ) Yes ( ) No If so, **please provide copies.**

Defendant's vehicle

Year: _____Make:_____ Model: _____

Was the vehicle drivable after the accident? ( ) Yes ( ) No

Do you have photos of the defendant's damaged vehicle? ( ) Yes ( ) No If so, **please provide copies.**

INJURIES

List in full detail *all symptoms that you experienced in the first 30 days after the accident.* Include emotional, mental, and physical symptoms. _____

_____

_____

List in full detail *all injuries you received as a result of this accident.* Include emotional, mental and physical injuries._____

_____

_____

List in full detail *all symptoms that you continue to experience as a result of this accident.*

_____

_____

List specific ways this accident has affected your life. Is there anything you are no longer able to do?

_____

_____

MEDICAL PROVIDERS

Please provide the following information for each and every medical provider who has treated you since the accident. This information is **very important**. Failure to provide information may cause medical expenses to be incorrect for which you may be liable.

❖ Did you go to a hospital emergency room? ( ) Yes ( ) No If so, was it the same day? ( ) Yes ( ) No

Which hospital? _____

Were you transported by ambulance? ( ) Yes ( ) No Which ambulance service? _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

❖ Medical Provider: _____

Address:_____

Phone #: _____ Fax #: _____

(Use back if necessary)

WAGE LOSS

Have you missed any time from work as a result of your injury? ( ) Yes ( ) No

If yes, please provide the following information for the employer for whom you were working at the time of the accident.

Name of employer_____ Phone #: _____

Job title & type of work: _____

a. Gross rate of pay $_____ ( ) hourly ( ) weekly ( ) monthly

b. How many days did you miss work because of injuries from ***this*** accident?: _____

POLICE RECORD

Have you ever been charged with a crime? ( ) Yes ( ) No. If so, please indicate the nature of the charge, the approximate date, the court where the charge was handled, and the ultimate resolution of the charge.

_____

_____

CONCLUSION

Is there any other information which you feel MAY be helpful to your case? Please express any feelings or frustrations this accident has caused in your life.

_____

_____

_____

I have read and completed the above information and state that it is true and correct to the best of my knowledge.

DATED this _____ day of _____, 20 ____ _____
Client Signature