

**PERSONAL INJURY/MOTOR VEHICLE ACCIDENT  
INTAKE SHEET**

**INSTRUCTIONS:** Answer all questions truthfully and completely. The information you enter in this questionnaire is confidential and protected by Attorney-Client Privilege. The information will not be disclosed to anyone outside of this office, except in the course of rendering legal services on your behalf, or unless otherwise required by law.

Date: \_\_\_\_\_

**INITIAL CLIENT STATEMENT**

**HAVE YOU CONSULTED WITH/SPOKEN TO ANOTHER ATTORNEY REGARDING THIS CASE?** \_\_\_\_\_

**IF SO, PROVIDE ATTORNEY'S NAME:** \_\_\_\_\_

**DO YOU HAVE A SIGNED RELEASE FROM THAT ATTORNEY?** \_\_\_\_\_

**PERSONAL INFORMATION**

Your Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County of Residence: \_\_\_\_\_ You have lived at current address since: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Facsimile No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ Pager/Beeper No: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Soc. Sec. No: \_\_\_\_\_ Driver's License No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ State/Country of Birth: \_\_\_\_\_

Best way to contact you: \_\_\_\_\_

Other names by which you have been known: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Facsimile No: \_\_\_\_\_

Work E-mail Address: \_\_\_\_\_

How long have you worked for this employer? \_\_\_\_\_

Position: \_\_\_\_\_ Salary/Earnings: \$ \_\_\_\_\_

Name of Emergency Contact, and relation to you: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EDUCATION:**

High School/G.E.D.: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Technical School: \_\_\_\_\_

College/University: \_\_\_\_\_ Years & Degree: \_\_\_\_\_

**SPOUSE'S INFORMATION**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Resided at current address since: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Facsimile No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ Pager/Beeper No: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Soc. Sec. No: \_\_\_\_\_ Driver's License No: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ State/Country of Birth: \_\_\_\_\_

Other names by which spouse has been known: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Facsimile No: \_\_\_\_\_

Work E-mail Address: \_\_\_\_\_

How long has spouse worked for this employer? \_\_\_\_\_

Position: \_\_\_\_\_ Salary/Earnings: \$ \_\_\_\_\_

Name of Emergency Contact, and relation to spouse: \_\_\_\_\_

Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EDUCATION:**

High School/G.E.D.: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_  
Technical School: \_\_\_\_\_  
College/University: \_\_\_\_\_ Years & Degree: \_\_\_\_\_

Nature of case / reason for seeking consultation with our office: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_  
\_\_\_\_\_

**OTHER PARTY INFORMATION**

Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
County of Residence: \_\_\_\_\_ Other party has lived at this address since: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Facsimile No: \_\_\_\_\_  
Cell Phone No: \_\_\_\_\_ Pager/Beeper No: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_ Driver's License No: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ State/Country of Birth: \_\_\_\_\_

Other names this person has been known by: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Work Facsimile No: \_\_\_\_\_  
Work E-mail Address: \_\_\_\_\_

How long has other party worked at this employer? \_\_\_\_\_

Position: \_\_\_\_\_ Salary/Earnings: \$ \_\_\_\_\_

Is other party represented by an ATTORNEY in this matter? \_\_\_\_\_ Yes \_\_\_\_\_ No

***If YES, please answer the questions below:***

Name of Attorney/Firm: \_\_\_\_\_

City where office located: \_\_\_\_\_ Phone: \_\_\_\_\_

Indicate whether this or any other attorney has taken any of the following actions (circle one):

*This or any other attorney **HAS / HAS NOT** represented other party in other matters (besides this case).*

*This or any other attorney **HAS / HAS NOT** Provided advice or other services to you regarding this case.*

*This or any other attorney **HAS / HAS NOT** Provided advice or other services to you regarding other matters.*

*This or any other attorney **HAS / HAS NOT** Talked with you in person or by telephone regarding this case.*

*This or any other attorney **HAS / HAS NOT** Sent a letter or other written communications to you related to this case.*

*This or any other attorney **HAS / HAS NOT** Served papers (by a sheriff or process server) upon you in this case.*

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-- GIVE AS MUCH DETAIL AS POSSIBLE)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 YOU (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? \_\_\_\_\_

**INSURANCE COVERAGE FOR DEFENDANT:**

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, CLINICS, HOSPITALS FOR THIS CLAIM:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

When did you last see the medical care provider? \_\_\_\_\_

When will you see the medical care provider again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

When did you last see the medical care provider? \_\_\_\_\_

When will you see the medical care provider again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see the medical care provider? \_\_\_\_\_  
When will you see the medical care provider again? \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Current Balance on Medical Bills: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see the medical care provider? \_\_\_\_\_  
When will you see the medical care provider again? \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Current Balance on Medical Bills: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see the medical care provider? \_\_\_\_\_  
When will you see the medical care provider 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:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**WITNESSES:**

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone No: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Position: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone No: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Position: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone No: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Position: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone No: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_



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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? \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE:**

Please list all doctors, clinics and hospitals for the last ten (10) years.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

When did you last see this medical care provider? \_\_\_\_\_

Reason: \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Is your recovery complete? Has the condition been cured, injury healed, completely? \_\_\_\_\_

If "No," please explain: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

When did you last see this medical care provider? \_\_\_\_\_

Reason: \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Is your recovery complete? Has the condition been cured, injury healed, completely? \_\_\_\_\_  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see this medical care provider? \_\_\_\_\_  
Reason: \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Is your recovery complete? Has the condition been cured, injury healed, completely? \_\_\_\_\_  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see this medical care provider? \_\_\_\_\_  
Reason: \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Is your recovery complete? Has the condition been cured, injury healed, completely? \_\_\_\_\_  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
When did you last see this medical care provider? \_\_\_\_\_  
Reason: \_\_\_\_\_  
Physical therapy? \_\_\_\_\_  
Is your recovery complete? Has the condition been cured, injury healed, completely? \_\_\_\_\_  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_