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FREE CONSULTATION

PERSONAL INJURY CLIENT QUESTIONNAIRE

Name: _____ Date: _____

Please list all other names by which you have ever been known, including marital and maiden names, nicknames, and aliases: _____

Home Address: _____

Prior addresses in the past 3 years (please indicate period of time and dates for each):

_____

_____

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Social Security # ____ - ____ - ____

Contact Preference: Home Phone: ____ Cell Phone: ____ Work Phone: _____ Other: _____

E-Mail Address: _____

Date of Birth: _____ Place of Birth (City & State): _____

Are you married? Yes ____ No ____

If yes, Date of Marriage: _____ Place of Marriage: _____

Spouse's Name: _____

Spouse's Cell Phone: _____ Spouse's Work Phone: _____

Have you ever been divorced or legally separated? Yes ____ No ____ If yes, please provide details.

_____

_____

_____

Please list the name, age, relationship and address of everyone, including children, who are dependent upon you for support.

Name: _____ Age: _____ Relationship: _____

Address: _____

PERSONAL INJURY QUESTIONNAIRE

Name: _____Age: ____ Relationship: _____

Address: _____

Name: _____Age: ____ Relationship: _____

Address: _____

Name: _____Age: ____ Relationship: _____

Address: _____

Injury or Accident

Date of Incident: _____Location of Incident: _____

Names, addresses, and telephone #'s (if known) of other people involved:

_____

_____

_____

_____

_____

State all injuries known to be a result of the accident:

_____

_____

_____

Length of time confined to bed: _____ Length of time confined to house: _____

Please state present physical conditions, including scars, disabilities, deformities and discomforts due to the injuries. _____

_____

_____

PERSONAL INJURY QUESTIONNAIRE

Physicians and Surgeons

Please list all physicians and surgeons you have seen for this injury (attach additional page if necessary).

Name: _____ Address: _____

Nature of treatment: _____

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

_____

Name: _____ Address: _____

Nature of treatment: _____

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

_____

Name: _____ Address: _____

Nature of treatment: _____

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

_____

_____

Name: _____ Address: _____

Nature of treatment: _____

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

Nurses, Therapists and Health Care Professionals

List all nurses, therapists, and health care professionals other than doctors and surgeons that you have seen (attach additional page if necessary).

Name: _____ Address:

Nature of treatment:

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

_____

PERSONAL INJURY QUESTIONNAIRE

Name: _____Address: _____

Nature of treatment: _____

Are you still under care? Yes ____ No ____ If yes, please provide detail. _____

_____

Employment History

Current or Most Recent Employer: _____

Employer Address: _____

Beginning Date: _____Ending Date: _____Position: _____

Job Description: _____

Beginning Pay Rate: _____Current or Last Pay Rate: _____

Have you ever missed work due to your injuries? Yes ____ No ____

If yes, list the dates you were unable to work. From: _____To: _____

Reason for leaving : _____

Employer Prior to last one listed: _____

Employer Address: _____

Beginning Date: _____Ending Date: _____Position: _____

Job Description: _____

Beginning Pay Rate: _____Current or Last Pay Rate: _____

Have you ever missed work due to your injuries? Yes ____ No ____

If yes, list the dates you were unable to work. From: _____To: _____

Reason for leaving: _____

Employer Prior to last one listed: _____

Employer Address: _____

Beginning Date: _____Ending Date: _____Position: _____

Job Description: _____

PERSONAL INJURY QUESTIONNAIRE

Beginning Pay Rate: _____Current or Last Pay Rate: _____

Have you ever missed work due to your injuries? Yes ____ No ____

If yes, list the dates you were unable to work. From: _____To: _____

Reason for leaving: _____

Education

Please list your highest educational level (high school, college, graduate school, professional training) with the name/address of the institution(s). _____

Name of Institution: _____

Address: _____

Do you have any special job training? Yes ____ No ____ If yes, please describe.

_____

_____

_____

Military Background

Have you ever been in the military? Yes ____ No ____ If Yes, Dates of Service: _____

Service Number: _____Branch: _____Type of Discharge: _____

Have you had any service-related injuries/disabilities? Yes ____ No ____ If yes, please describe.

_____

_____

_____

Disability %: _____ Present condition of service-related injury/disability: _____

Do you receive payments for service-related injuries? Yes ____ No ____

If yes, please provide: Amount _____ Frequency _____ Source (Veterans, Social Security, Private Insurance, Other)_____

Have you ever been rejected for military service because of physical, mental, or other reasons?

Yes ___ No ___ If yes, please indicate reason(s). _____

_____

_____

Prior Claims and Lawsuits

Please list every claim you have ever made for personal injury or property damage (attach additional page if necessary).

Our adversaries will inquire about your history of legal claims and lawsuits. It is important that you disclose your complete history to us. You still have a right to seek reimbursement for your injuries even if you have been involved in prior legal actions. You will not be penalized by a court or jury if the claims were reasonable and genuine.

Date: _____Nature of Claim: _____

Against Whom: _____

Result: _____

Date: _____Nature of Claim: _____

Against Whom: _____

Result: _____

Date: _____Nature of Claim: _____

Against Whom: _____

Result: _____

Date: _____Nature of Claim: _____

Against Whom: _____

Result: _____

Date: _____Nature of Claim: _____

Against Whom: _____

Result: _____

PERSONAL INJURY QUESTIONNAIRE

Police Record

Please list all prior arrest information.

The defense will investigate your background. We must be prepared against any unfavorable evidence that is uncovered. Evidence of prior criminal acts might be used against you at trial, no matter how mitigating the circumstances.

Date _____ Location: _____ Charge: _____ Result: _____

Date _____Location: _____Charge: _____Result: _____

Date _____Location: _____Charge: _____Result: _____

Date _____Location: _____Charge: _____Result: _____

Workers' Compensation

Have you ever filed a claim for Workers' Compensation? Yes ____ No ____

If yes, please describe your injury: _____

Date of injury: _____ Location of injury: _____

Are you presently receiving payments? Yes ____ No ____

If yes, Amount: _____ Frequency: _____

Who is handling your Workers' Compensation claim? _____

Are you receiving disability payments from sources other than Worker's Compensation?

Yes ____ No ____ If yes, Amount: _____ Frequency: _____ Source: _____

Prior Physical Conditions

Please list every physical examination you have had during the last 10 years for any injury, including those related to employment, selective service, and armed forces (attach additional page if necessary).

Date: _____ Name of Doctor: _____Location: _____

Purpose: _____Result: _____

Date: _____Name of Doctor: _____Location: _____

Purpose: _____Result: _____

PERSONAL INJURY QUESTIONNAIRE

Date: _____Name of Doctor: _____Location: _____

Purpose: _____Result: _____

Date: _____Name of Doctor: _____Location: _____

Purpose: _____Result: _____

Date: _____Name of Doctor: _____Location: _____

Purpose: _____Result: _____

Date: _____Name of Doctor: _____Location: _____

Purpose: _____Result: _____

Prior Accidents and Injuries

Please list all prior accidents, whether they resulted in a claim for damages or not.

Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem.

Date: _____Location: _____

Nature of Accident: _____

Extent of Injuries: _____

Date: _____Location: _____

Nature of Accident: _____

Extent of Injuries: _____

Date: _____Location: _____

Nature of Accident: _____

Extent of Injuries: _____

Date: _____Location: _____

Nature of Accident: _____

Extent of Injuries: _____

Date: _____Location: _____

Nature of Accident: _____

Extent of Injuries: _____

PERSONAL INJURY QUESTIONNAIRE

Illness or Disease

We must know about all prior illnesses, either before or since your accident. This is particularly true if there is any connection with your present physical complaints. The defendant will have access to a complete history of your past physical condition as well as your veteran's records, insurance records, and medical/hospital records.

Date: _____Nature of Illness: _____

Duration: _____Treated by: _____

Hospitalized? _____Yes ____ No ____ If yes, when? _____

Name and address of hospital: _____

Date: _____Nature of Illness: _____

Duration: _____Treated by: _____

Hospitalized? _____Yes ____ No ____ If yes, when? _____

Name and address of hospital: _____

Date: _____Nature of Illness: _____

Duration: _____Treated by: _____

Hospitalized? _____Yes ____ No ____ If yes, when? _____

Name and address of hospital: _____

Have you ever had trouble with your eyes? Yes ____ No ____ Ears? Yes ____ No ____ If yes, please check all that apply:

Glasses/contacts: _____ Artificial eye: _____ Hearing aid: _____ Other: _____

Have you ever worn a brace or back and neck support? Yes ____ No ____

Have you ever worked with radioactive substances, asbestos, or any other substance alleged to cause diseases, such as cancer? Yes ____ No ____

Have you ever been denied health or life insurance? Yes ____ No _____

If yes, name of insurance company _____ Reason: _____

Have you ever been treated for alcoholism, drug addiction or venereal disease? Yes ____ No ____

If yes, please describe. _____

Signature: _____**Date:** _____