

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: _____

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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. _____

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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. _____

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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: _____

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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) _____

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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: _____

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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: _____

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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: _____

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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:** _____