CLIENT QUESTIONNAIRE-PERSONAL INJURY

(FILL IN COMPLETELY)

TODAY'S DATE: _____ COURT DATE _____

CLIENT' NAME: _____ M_____ F_____

FULL ADDRESS: _____

_____

HOME TELEPHONE: _(____)_____ WORK TELEPHONE: _(____)_____

AGE: _____ DATE OF BIRTH: ____/____/____ SSN#: _____/_____/_____

MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED

EMPLOYER: _____

FULL ADDRESS: _____

_____

SUPERVISOR/TITLE: _____TYPE OF WORK:_____

PAY PER HOUR: _____ STARTING DATE OF EMPLOYMENT _____

NAME & AGE OF SPOUSE (S): _____

NAME & AGE OF CHILDREN: _____

HOW MUCH TIME MISSED FROM WORK, DUE TO THIS ACCIDENT? _____

WHERE DID ACCIDENT OCCUR?_____

CITY/CTY _____ WHICH POLICE DEPT. RESPONDED? _____

DATE OF ACCIDENT: ____/__/_____ SUN MON TUE WED THU FRI SAT SUN

WEATHER: RAIN CLEAR ICY COLD WET MISTY CLOUDY

TIME: _____ LIGHT DARK DUSK DAWN

WERE YOU THE: DRIVER PASSENGER PEDESTRIAN OTHER

DO YOU HAVE AUTO INSURANCE: _____ NAME OF CARRIER _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

OPPOSING PARTY NAME: _____PHONE: (____)_____

OPPOSING PARTY INSURANCE (NAME OF CARRIER): _____

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OPPOSING PARTY POLICY #: _____ CLAIM #: _____

AGENT: _____ PHONE: _(___)_____

MAKE/MODEL OF VEHICLE YOU OCCUPIED OR OPERATED: _____

WHERE IS VEHICLE LOCATED: _____ WAS IT DRIVEABLE?_____

ANY PASSENGERS IN YOUR VEHICLE? _____ IF SO, HOW MANY? _____

ANY OF THE PASSENGERS INJURED, IDENTIFY: _____

ADVERSE PARTY'S VEHICLE: _____ WAS IT DRIVEABLE? _____

ANY PASSENGERS IN ADVERSES VEHICLE? _____ INJURED: _____

WHAT HOSPITAL WERE YOU TAKEN TO? _____

IN PATIENT _____ OUT PATIENT _____ ADDRESS: _____

LIST ANY DOCTORS WHO TREATED YOU: _____

_____

LIST THE DATES OF VISITS TO THE DOCTOR(S) OR CHIROPRACTORS: _____

_____

ANY PREVIOUS ACCIDENTS? IF YES, GIVE THE DETAILS: _____

_____

_____

BRIEF DESCRIPTION OF ACCIDENT: _____

_____

WHAT DID ADVERSE DRIVER SAY TO YOU? _____

WHAT INJURIES DID YOU RECEIVE? _____

_____