INITIAL INTAKE FOR PERSONAL INJURY CLIENT

TYPE OF CASE

( ) MOTOR VEHICLE ACCIDENT ( ) MEDICAL MALPRACTICE ( ) SLIP AND FALL

( ) OTHER: _____

STATUTE OF LIMITATIONS

DATE OF ACCIDENT: _____ STATUTE DATE: _____ GTCA _____

CLIENT INFORMATION

NAME _____

ADDRESS: _____

_____

TELEPHONE :(H) _____

(C) _____

EMAIL: _____

D.O.B. _____

SSN: _____

Are you married? _____ If so, spouse's name: _____

CLIENT'S HEALTH INSURANCE INFORMATION: _____

CLIENT'S AUTOMOBILE INSURANCE INFO: _____

PROPERTY DAMAGE: Pending _____ Settled _____ If so, how much? _____

UM: Yes ___ No ____; **Med Pay:** Yes ____ No ____

REFERRED BY: Internet ____ Former Client _____ If so, who? _____ TV _____

Telephone Book ____ Attorney _____ If so, who _____ Other: _____

INVESTIGATION

1. Investigated: Yes _____ If so, who _____ No _____
2. Passenger _____ Driver _____
3. Location: _____ County: _____

4. Description of Accident: _____

_____

_____

_____

_____

_____

DEFENDANT'S INFORMATION:

NAME: _____

INSURANCE: _____

CLAIM NO: _____

5. Did the Defendant receive any treatment for injuries on the scene? _____

_____

6. Did the Defendant make any type of admission as to fault or being on their cell phone or being distracted by anything? _____

_____

WITNESSES **NOTES**

7. **Name:** _____ _____

Telephone #: _____ _____

Address: _____ _____

Name: _____ _____

Telephone #: _____ _____

Address: _____ _____

8. Are there any photographs of the vehicles, accident scene or injuries sustained in the accident? ____ If so, who is in possession of those? _____

INJURIES AND MEDICAL TREATMENT

9. Please list all injuries sustained in this accident: _____

_____

_____

10. Please list all medical providers in which you have received medical treatment for the injuries sustained in this accident:

a. Ambulance: Yes ____ If so, who? _____ or No _____;

b. Emergency Room: _____ and date of service _____

c. Were there X-rays _____, MRIs_____ or CAT Scans _____ performed:

Yes _____ If so, of what body part? _____ or No ___

d. Other Medical Providers: _____

_____

_____

_____

11. Have you lost any wages due to this accident? And if so, what employer and how many hours at what rate of pay? _____

_____

PAST MEDICAL TREATMENT

12. Have you ever previously injured the same body part or parts injured in this accident? _____; If so, please state the following:

a. Was it due to an automobile accident or work related injury? _____ If so, give the date of accident, type of injury, name of work place, whether there was an insurance claim, treatment received, medical providers, etc. _____

13. List all accidents or workers' compensation cases you have been involved in. _____

MISC.

14. Have you ever been convicted of or pled guilty to any misdemeanors or felonies?

15. Do you owe any back child support?

16. Are you a Medicare recipient?

- Please make copy of insurance card. Thank you. ☺