Please print out and fill out the form below. Feel free to use additional pages if needed. For clarity, please label continuation responses according to section and item numbers.

PERSONAL INJURY INTAKE

I. CLIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____SSN: _____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Pager/Cell Phone:_____ E-mail:_____

Pedigree _____

☐ Spouse: ☐ Guardian:

Date of Birth: _____ SSN: _____

Child: _____ DOB: _____

Child: _____ DOB: _____

Critical Deadlines: _____

City/Public Authority Involved? Yes ☐ No ☐

Notice of Claim Deadline: _____

Statute of Limitations: _____

Automobile Accident Client Interviewed By: _____ Date: _____

Referral Source: _____ File No.: _____

II. EMPLOYMENT INFORMATION

Employer: _____ Client's Occupation:_____

Address: _____

Weekly/Biweekly Salary: _____ Date Employment Commenced: _____

No. of Hours Worked Per Day: _____ No. of Day Worked Per Week Week:_____

Supervisor: _____ Phone No.: _____

Last Day Worked Before Accident: _____

Date Returned: _____ Light/Restricted Duty?: _____

How Long Were You Confined To Bed: _____

How Long Were You Confined Home: _____

Employer's Disability Carrier: _____

Address of Employer's Disability Carrier: _____

Disability Carrier's Policy No.: _____

Workers Compensation Carrier: _____

Address of Workers Compensation Carrier: _____

WCB Carrier Case No.: _____

III. EDUCATION

School Name: _____

Address: _____

Grade Level: _____

IV. ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____

Location Of Accident: _____

Client Was Traveling On What Street/Road: _____

Offending Vehicle Was Traveling On What Street/Road _____

Weather: _____ Plaintiff's Position In Vehicle: _____

Accident Description: _____

_____

_____

_____

_____

_____

Precinct: _____ Accident No.: _____

Officer's Name: _____ Officer's Badge No.: _____

V. Diagram Of The Accident:

VI. WITNESSES

Witness #1 Name: _____
Address: _____
Phone Number: _____

Witness #2 Name: _____
Address: _____
Phone Number: _____

Witness #3 Name: _____
Address: _____
Phone Number: _____

VII. VEHICLE INFORMATION

☐ Our client was the _____ in vehicle # 1 (Owner/Operator/Passenger).

☐ Our client was a pedestrian.

Vehicle No. 1: (Host Vehicle)

Vehicle Plate No.: _____ Vehicle's Year: _____
Vehicle's Make: _____ Vehicle's Model: _____
Vehicle's VIN #: _____
Owner's Name: _____
Owner's Address: _____
Leaseholder's Name: _____
Address: _____
Operator: _____
Address: _____
Carrier/Insurance Code: _____
Address: _____
Policy Holder: _____ Policy No.: _____
Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 2:

Vehicle Plate No.: _____ Vehicle's Year: _____
Vehicle's Make: _____ Vehicle's Model: _____
Vehicle's VIN #: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Address: _____

Operator: _____

Address: _____

Carrier/Insurance Code: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 3:

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN #: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Address: _____

Operator: _____

Address: _____

Carrier/Insurance Code: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Medical Care _____

Injuries Sustained: _____

_____

Emergency Care At Scene?

Ambulance: Yes ☐ No ☐

VIII. Hospitals

Hospital #1: _____

Date Of Treatment: _____ Date Of Discharge: _____

Address: _____

Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

Hospital #1: _____

Date Of Treatment: _____ Date Of Discharge: _____

Address: _____

Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

IX. Physicians

1. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

2. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

3. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

Priors _____

Has The client ever been involved in an automobile or any other type of accident? Yes ☐ No ☐

If yes, complete the following:

DOA: _____ Place: _____

Description: _____

_____

Injuries Sustained: _____

_____

List the medical providers who rendered treatment: _____

_____

Did the client commence a lawsuit? Yes ☐ No ☐

If Yes, Please list the name and address of client's prior counsel:

_____

List ALL past and current primary or treating physicians below.

1. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

2. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

3. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____

Priors _____

Description: _____

_____

Date: _____

_____
Client Signature