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