# CLIENT INFORMATION QUESTIONNAIRE

**Personal and family history** **DATE:** ____________________

1. Your Full Name: ______________________________
Present Home Address: ______________________________
______________________________

Your Home Phone No.: (______) ____________________
Your Cell Phone No.: (______) ____________________
Your Fax No.: (______) ____________________

Present Employer: ______________________________
Present Work Address: ______________________________
______________________________

Your Work Phone No.: (______) ____________________
Your Work Fax No.: (______) ____________________

2. Have you ever used, or been known by, any name other than that shown above? Yes / No (circle one) If so, list the other names, and the state when and why the other names were used.

______________________________
______________________________

3. Please list any and all addresses where you have resided during the past ten years, and the period of time at each residence, including dates:

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

Your Social Security No.: ______________________________
Your Date of Birth: ______________________________

4. Place of Birth: ______________________________

   a. Have you ever used any other birth date or birthplace? Yes / No (circle one)
   b. If yes, please give details: ______________________________
   ______________________________

Are you married? Yes / No (circle one)
If yes: Name of Spouse: ______________________________
Date/City of marriage: ______________________________
Are you living together now? ______________________________

Have you been previously married? Yes / No (circle one)
If yes: Name & Address of Ex-Spouse: ______________________

Date/City of marriage: ______________________
Date/City of divorce/annulment: ______________________

Name & Address of Ex-Spouse: ______________________

Date/City of marriage: ______________________
Date/City of divorce/annulment: ______________________

5. List the names, addresses, and ages of all those (including children) who are dependant on you for support, and your relationship to each.

| NAME | ADDRESS | AGE | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**THE ACCIDENT**

6. Date: ______________ Time: ______________

City: ______________ County: ______________

Weather: ______________

Describe the location of accident (as to intersections or fixed objects): ______________

Police Department investigating the accident: ______________

In your own words, give a comprehensive account of the facts leading up to, during and following the accident or incident you are complaining about: ______________

How did you leave the scene of the accident? ______________________________

______________________________________________________________

Were photographs or videotapes taken at the scene of the accident? Yes / No (circle one)

If so, please state the name and address of the person who took them and the person who has possession of them: ______________________________

______________________________________________________________

Was the news media present at the scene? Yes / No (circle one)
If so, which station or newspaper: ______________________________

Were you questioned by the police? Yes / No (circle one)

Did you give or sign a statement? Yes / No (circle one)
If so, for whom? ____________________ When? ____________________
Do you have a copy of the statement(s)? Yes / No (circle one)

Have you been questioned by an insurance adjuster or investigator? Yes / No (circle one)
If so, when? ____________________ Where? ____________________
Name of person who questioned you? ______________________________
Was anyone else present? ______________________________
Did you sign any papers? ______________________________
Were you given a copy? ______________________________

Please list below everything you believe the Defendant did that caused or contributed to the cause of the accident. ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Diagram of accident**

Please draw a detailed diagram of accident scene and vehicles.

**Witnesses**

7. Please provide us with a list of all witnesses and their addresses, and any other people who may be of assistance in testifying about your case.

NAME ADDRESS RELATIONSHIP

**Vehicles involved in the accident**

8. Please provide the following information relating to your vehicle:

Make and model: ______
License tag number: ______
Names or all persons who have an ownership interest: ______

If the vehicle is financed, name of finance company: ______

Location of vehicle at the present time: ______

Has anyone taken photographs of the vehicle? Yes / No (circle one)

If yes, please state the name and address of the person who took them and who has possession of the photographs: ______

**Injuries and damages from this accident**

9. State all injuries known or believed by you to have been received as a result of this accident.

Disability - length of time confined to bed: ______

And thereafter, to house: ______

State your present physical condition - - scars, disabilities, deformities, discomforts, etc., resulting from the injuries received in this accident.

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Activities eliminated or hampered as a result of this injury. List here all the usual activities that you have not been able to perform since the accident, such as cutting grass, dancing, etc.

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Has anyone taken photographs or videotapes of your injuries? Yes / No (circle one)

If yes, please state the name and address of the person who took them and the person who has possession of them. ______________________________
_______________________________________________
_______________________________________________

**Medical treatment and hospitalization AS A RESULT OF THIS ACCIDENT**

10. (a) Hospitalizations

Name and address of hospital: ______________________________
_______________________________________________
_______________________________________________

Date admitted: ____________ Date Discharged: ________________

Why admitted: ______________________________

Nature of treatment: ______________________________

(b) All healthcare providers who have seen or treated you AS A RESULT OF THIS ACCIDENT

Name: ____________________
Address: ____________________
Phone No. ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

Name: ____________________
Address: ____________________
Phone No. ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

Name: ____________________
Address: ____________________
Phone No. ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

Name: ____________________
Address: ____________________
Phone No. ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

Name: ____________________
Address: ____________________
Phone No. ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

(c) All nurses or therapists who have treated you as a result of this accident or incident:

Name: ____________________
Phone No. ____________________
Address: ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

Name: ____________________
Phone No. ____________________
Address: ____________________
Nature of treatment: ____________________
Date care began: ____________ Still under care? ____________

**"Out of pocket" expenses or obligations you now claim**

11. (a) Hospitals — Amount

___

___

(b) Doctors — Amount

___

___

(c) Nurses — Amount

___

___

(d) Medical appliances — Amount

___

___

(e) Drugs and medicines — Amount

___

___

(f) Ambulance — Amount

___

___

(g) Domestic/household help — Amount

___

___

(h) Transportation expenses — Amount

___

___

(i) Property damage — Amount

___

___

(j) Miscellaneous expenses — Amount

___

___

***NOTE:*** ***Please keep all bills and receipts and turn them over to your attorney.***

## INSURANCE AND WORKER'S COMPENSATION

### Your automobile insurance

12. Name and address of automobile insurance company: ______________________________

____________________________________________________________________________

Policy number: _______________________________________________________________
Claim number: ________________________________________________________________
Adjuster's name: ______________________________________________________________
Vehicles listed on policy: _______________________________________________________

Personal injury protection coverage: ________________________________________

Liability coverage? ______________________ Amount: __________________________

Uninsured motorist coverage? _____________ Amount: __________________________

Medical payments covered? ______________________________________________

Amount? _______________________________________________________________

Collision insurance? ______________________ Deductible amount? ________________

### Health Insurance

Name and address of health insurance company: _______________________________

________________________________________________________________________

Policy number: _________________________________________________________

### Worker's Compensation

Where you injured on the job in this accident? _________________________________

Are you receiving payments at present? ______________________________________

If so, explain: _________________________________________________________

________________________________________________________________________

Name and address of the attorneys who are handling the worker's compensation at present: ________________________________

________________________________

________________________________

**Social Security or Medicare**

Have you received Social Security benefits or Medicare benefits as a result of this accident?

________________________________

________________________________

**Educational background**

What education have you had, including any special employment training? ________________________________

________________________________

________________________________

________________________________

________________________________

________________________________

**Work background**

13. Were you employed at the time of the accident? ________________________________

 a. If so, state name and address of employer: ________________________________

 ________________________________

 b. What was your job title, or the type of work you were doing? ________________________________

 ________________________________

 c. What was your rate of pay? ________________________________

 d. How many hours per week were you working regularly immediately before the accident? ________________________________

 e. When were you first employed by the company for which you were working at the time of the accident? ________________________________

f. Have you remained in the same job since that date? ____________________

g. If not, state the reason for the termination of employment? ____________________

____________________

h. Have you missed any time from work as a result of your injury? If so, list the dates you were unable to work because of your injury:

____________________

i. Have you, before this accident, lost time from work due to an injury? ____________ If so, give details: ____________________

____________________

j. Did you lose wages for the periods of time missed from work because of this accident? ____________________

k. Have you received any increases or decreases in your pay since the accident?

____________________

If so, explain: ____________________

l. If you have changed jobs since the accident, give a summary of your present job, showing name and address or employer, rate of pay, house, type of work, etc.

____________________

____________________

____________________

**Employment record**

14. List your employment records as far back as you can remember. Your past employment record is important in determining your disability from an occupational viewpoint.

Name: ____________________

Address: ____________________

Employed from: ____________ to: ____________

Job: ______________________________________________

Reason for leaving: ______________________________________

Name: ____________________________________________

Address: __________________________________________

Employed from: _______________ to: ____________________

Job: ______________________________________________

Reason for leaving: ______________________________________

**Military background**

15. Have you ever been rejected for military service because of physical, mental, or other reasons? ______________________________________

    a. If so, explain: ____________________________________

    b. Have you ever served in the military? __________ If so, please state branch of military: ____________________________________

    Service Serial No.: ____________________________________

    Dates of service: From: ______________ To: ______________

    Type of discharge: ____________________________________

    c. Any service-connected injuries or disabilities: ________________

    Details: ____________________________________________

    d. Percentage of disability: ____________________________

Present condition of service-connected injury or disability:

____________________________________________________

Do you receive payments for service-connected injuries or disability?

____________________________________________________

**Prior claims and lawsuits**

19. We know there have been many cases damaged beyond repair by a history of other claims and lawsuits that the attorney did not know about. It is not the fact that one has had other claims or lawsuits that is important, for one will not be penalized by a Court or jury in the claims are reasonable and genuine. It is the denial of previous claims and suits that damages the case. List every claim you have ever made for personal injury or property damage, and give details. This includes claims under the state worker's compensation laws, railroad sickness benefits, and the longshoremen's harbor workers' act. If you have made no claims and filed no lawsuits please state "none."

Date:____________________ Nature of claim: ____________________

Against whom: ______________________________________

Suit filled: ______________________________________

Result: ______________________________________

Date:____________________ Nature of claim: ____________________

Against whom: ______________________________________

Suit filled: ______________________________________

Result: ______________________________________

**Prior accidents and injuries**

20. Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem. List here every such incident whether it resulted in a claim for damages or not, stating the date, place, and nature or the accident, and the extent of your injuries. If you have had no prior accidents or injuries, please state "none."

Date: _______________ Place:______________________________

Nature of accident or injury: ______________________________

Extent of injury: ______________________________________

Name of doctors and hospitals, and their addresses: ____________________

________________________________________________________

________________________________________________________

**Medical history**

21. Prior physical examinations or treatment

List here every physical examination or treatment for any condition you have had during the last ten years stating the date, name of the doctor or facility, and result, as fully as you can recall.

Date: ____________________ Time: ______________________________________

Doctor's/facility's name: ______________________________________________

Address: ________________________________________________________________

Purpose: ____________________ Result: ____________________________________

Date: ____________________ Time: ______________________________________

Doctor's/facility's name: ______________________________________________

Address: ________________________________________________________________

Purpose: ____________________ Result: ____________________________________

Date: ____________________ Time: ______________________________________

Doctor's/facility's name: ______________________________________________

Address: ________________________________________________________________

Purpose: ____________________ Result: ____________________________________

**Accidents or injuries after this accident**

22. If you have had any accident or injury since the one for which we are representing you, please state as to each:

Date: __________________ Time: ________________________________________

Place: __________________________________________________________________

How it happened: ________________________________________________________

Were you insured: _____________________ By whom?: _______________________

Names and dates of medical treatment or hospitalization and names and addresses or treating physicians:

____________________________________________

____________________________________________

____________________________________________

____________________________________________

**Police record**

23. It is the law in this state and elsewhere, that if a person has a criminal record, no matter how long ago, nor how mitigating the circumstances, that fact under certain circumstances may be proved against that party and commented on at the trial of the case. The denial of a criminal record increases the chance that the subject may be brought up at trial. The defense lawyers will investigate your background thoroughly. Therefore, it is extremely important that you discuss any criminal matter with your attorney. Please indicate below if you have a criminal record and discuss it with us as soon as possible.

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________