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PERSONAL INJURY QUESTIONNAIRE

CLIENT INFORMATION:

Name: _____ Spouse_____

How did you hear about our office (phone book?) or who referred you:_____

List any other names you have used or been known by other than shown above, stating when and why you used such other name(s):

_____

Current Address:_____

Phone: Home #_____ Cell #_____

Business #_____ Message #_____

Drivers License #_____ Email Address:_____

Date of Birth:_____ Social Security #:_____

Occupation / Employer:_____

Duties:_____

Dates not worked due to accident:_____

_____

(YOUR) Insurance Companies:

Auto_____Policy #:_____Claim #_____

Health_____Policy #:_____

Auto Policy Coverage:_____

Your Insurance's Adjuster:_____

DEFENDANT'S INFORMATION:

Name:_____

Address:_____

Phone #_____

Driver's License #:_____

Defendant's Insurance Company:

Auto_____Policy #:_____Claim #_____

Other (ex: Home Owners):_____ Policy #:_____

Insurance Coverage:_____

Defendant's Insurance Adjuster:_____

OTHER ACCIDENTS AND INJURIES:

Your attorney must know <u>all your past accident and injuries</u>. If your attorney does not know of your past accident / injury history he can not properly handle your case. One will not be penalized by the courts for past claims or lawsuits if they were reasonable. Failure to mention other accidents and/ or injuries can undermine your lawsuit, no matter how trivial they may seem. Therefore, please list every accident and / or injury, whether it resulted in a claim for damages or not**.**

State the DATE, PLACE, NATURE OF INCIDENT AND / OR INJURIES: If none, so state:

_____

_____

_____

POLICE RECORD:

It is the law in California that if a person has a criminal record, no matter how long ago, or what the circumstances, that may be brought up at trial. The defense will make a complete investigation of your background, and we must be prepared against development of unfavorable evidence. **Therefore, please list <u>ALL ARRESTS</u>, if any, and state the DATE, PLACE, CHARGE, and RESULT OF THE ARREST:**

_____

_____

_____

NATURE OF ACCIDENT:

Date of Accident:_____ Time of Day:_____

Location of Accident:_____

If it was an AUTO ACCIDENT please state:

Who was the DRIVER of your vehicle:_____

Who were PASSENGERS OF YOUR VEHICLE:_____

Number of People in your vehicle:_____ Number of people in other vehicle:_____

In what City did the accident occur:_____ County:_____

Name of the street, road or highway:_____

What direction were you traveling: North_____ South____ East _____ West ____

Were you struck from: Behind ____ Front ____ Left Side ____ Right Side ____

Accident Report by: (ie: CHP / Police)_____Report #:_____

DETAILS OF THE ACCIDENT:

Names, addresses, phone numbers of Witnesses:_____

_____

_____

Circumstances/Type of Accident:_____

_____

_____

In your own words please describe the accident:_____

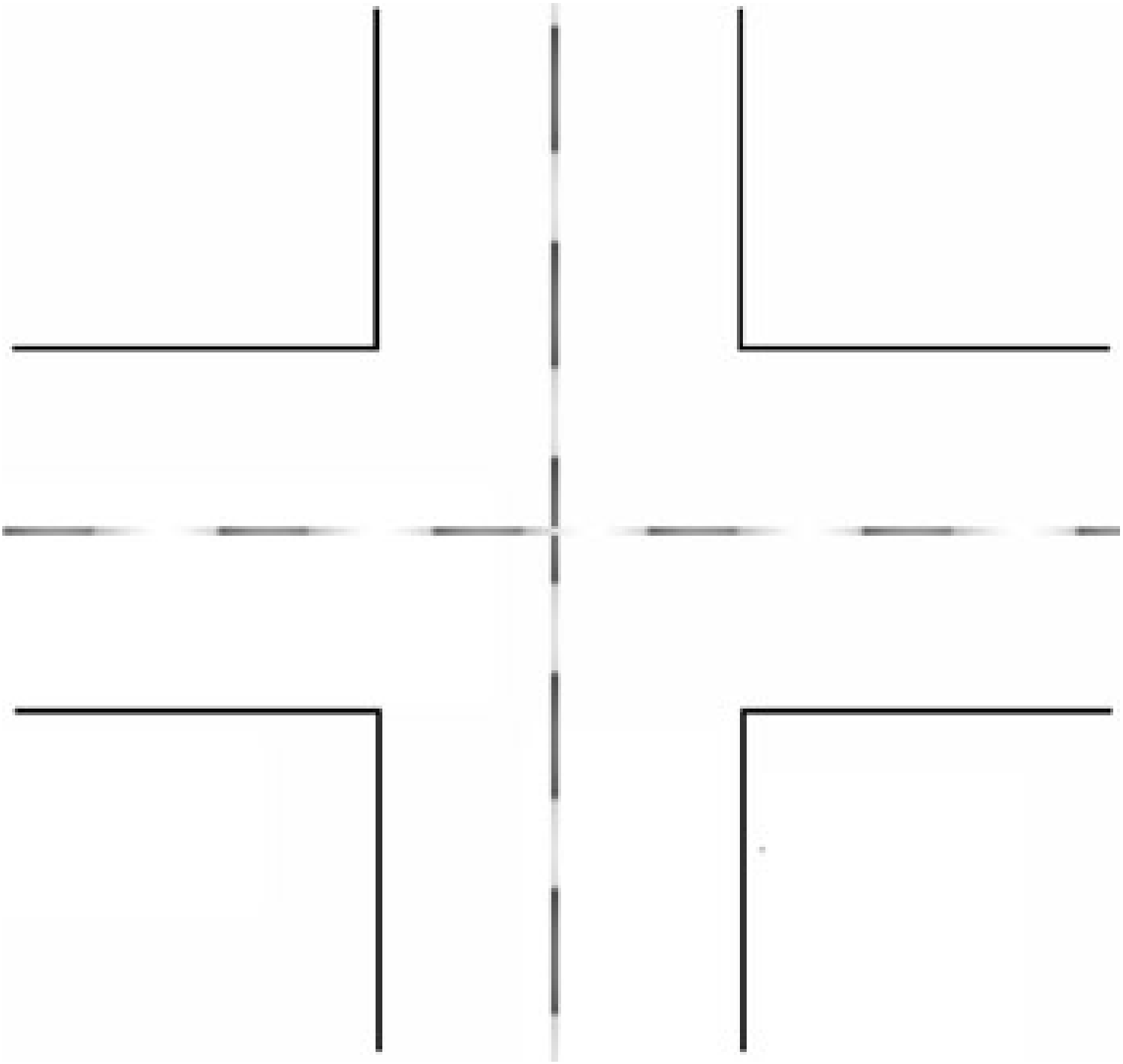
_____

_____

_____

_____

Please diagram how the accident happened:



PRIOR INJURIES:

Did you have any physical complaints before the accident: YES ____ NO _____

If so, please list the type of injury, your treating physician of that injury, and type of treatment:

_____

_____

INJURIES FROM ACCIDENT:

Where you taken from the accident by ambulance / flight care: YES ____ NO _____

PLEASE DESCRIBE HOW YOU FELT:

DURING the accident:_____

_____

IMMEDIATELY after the accident:_____

_____

The **NEXT** day:_____

_____

What treatment did you receive as a result of the accident (doctors / physical therapy / hospitals / ambulance):

Medical Provider 1:_____

Medical Provider 2:_____

Medical Provider 3:_____

Medical Provider 4:_____

Medical Provider 5:_____

Medical Provider 6:_____

Other Medical Providers:_____

_____

_____

What are your present **CONDITIONS and SYMPTOMS**: _____

_____

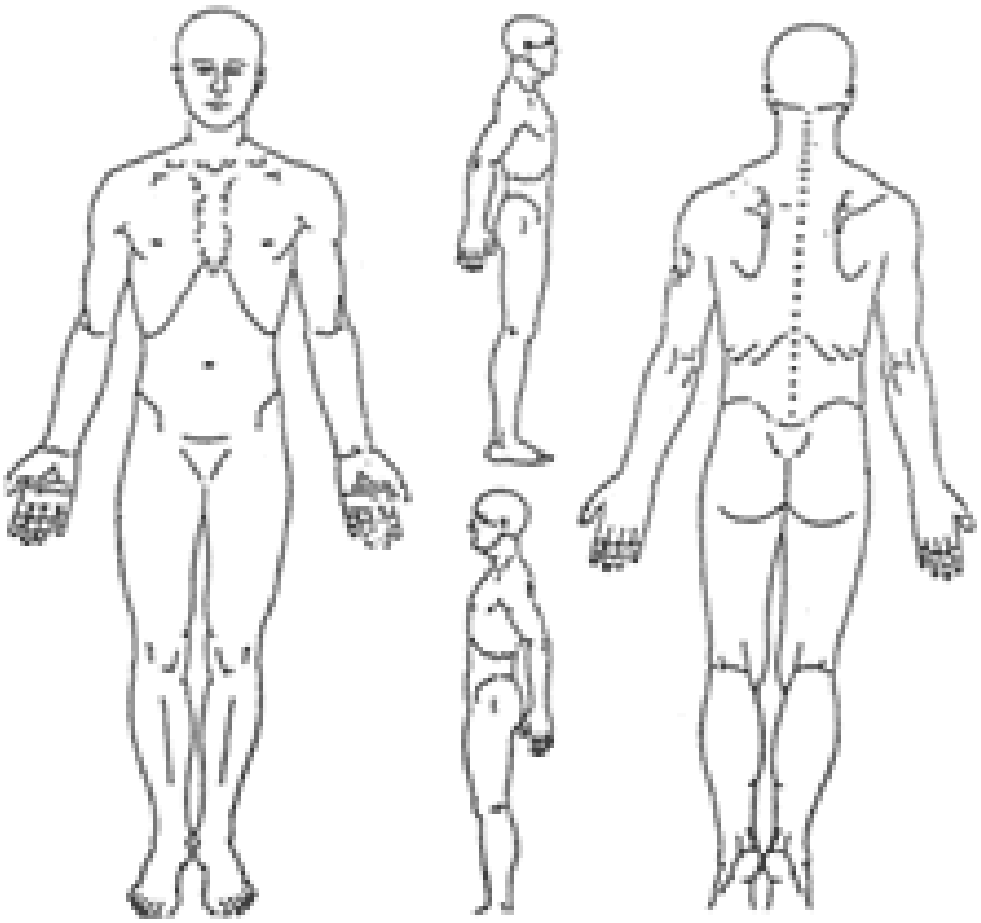
CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

( ) Headaches	( ) Loss of Memory	( ) Depression
( ) Tensions	( ) Irritability	( ) Numbness
( ) Cold Feet	( ) Cold Sweats	( ) Numbness in Fingers
( ) Stiff Neck	( ) Cold Hands	( ) Numbness in Feet
( ) Cold Chest	( ) Back Pain	( ) Sleeping Problems
( ) Nervousness	( ) Fever	( ) Ringing Ears
( ) Driving Anxiety	( ) Dizziness	( ) Sharp Pain in Arm/Feet
( ) Bleeding	( ) Constipation	( ) Loss of hair
( ) Nausea	( ) Loss of Taste	( ) Shortness of Breath
( ) Diarrhea	( ) Loss of Smell	( ) Buzzing in Ears
( ) Upset Stomach	( ) Loss of Vision	( ) Flush Face

Do you have pain that radiates / travels from your neck into your arms and hands? _____

Do you have pain that radiates / travels from your back into your butt, legs or feet? _____

Please indicate below where you have pain by placing an X at pain locations:



ACTIVITIES SINCE THE ACCIDENT:

Please list all of your daily activities and special interests (hobbies) that you have NOT been able to perform since the accident due to your injuries. (Include such things as yard work and recreational activities):

_____

_____

Did you have to hire someone to take care of your chores (ie. yard work, house work, shopping, business, etc.)
YES ____ NO ____

If you did hire someone, please list their name / address / and amount paid to date:

_____

_____

GENERAL BACKGROUND:

Your attorney must know about your background. Your educational and physical history may have an important bearing upon your case.

Education

High School:_____

College / Vocational Training:_____

WORK BACKGROUND:

Where you employed at the time of the accident? YES ____ NO ____

Employers name, address and phone number: _____

_____

What was your job title and duties: _____

_____

How many hours a week were you working before the accident?_____

How many hours a week are you working since the accident?_____

What was your rate of pay (hourly amount, etc.):_____

Have you remained at the same job? YES ____ NO ____

INCOME LOSS

If you have missed work, give the dates you missed work so far:

_____

_____

Did you lose wages for the period of time you missed work? YES ____ NO ____

If so, please list your hourly rate:_____ monthly rate: _____

Total amount of wages lost so far:_____

If you have changed jobs or are no longer employed, please give a summary of your reason for leaving your employer at the time of the accident:

_____

_____

If you have changed jobs since the accident please list your present employer / job, rate of pay, and hours worked:

_____

_____

Please list your employment records as far back as possible: _____

_____

PROPERTY DAMAGE:

Do you attribute any loss of or damage to a vehicle: Yes No

Do you have photos of the damage to your vehicle: Yes No (if not, please take photos immediately)

Make and Model of Vehicle:_____ Who owned vehicle:_____

Location of Damage on Vehicle (ie front, back, etc.):_____

Has a written estimate for repair been done? Yes No Amount of Estimate for Repair: _____

Who Prepared the Estimate:_____

Was the vehicle repaired? Yes No Who repaired the vehicle: _____

What was the cost of repair: _____ Do you still have the vehicle? Yes No