

**Personal Injury Case – Client Information**

**PERSONAL INFORMATION**

*It is important for us to have complete information about you.*

Full name: \_\_\_\_\_ Soc. Sec.#: \_\_\_\_\_

List all other names by which you have ever been known. Include marital and maiden names, nicknames and Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Present home address: \_\_\_\_\_

Present business address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

List the addresses where you have resided during the past 10 years. Indicate the period of time at each residence, including dates:

<u>Address</u>	<u>Dates</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*Attach additional sheets if necessary*

**FAMILY INFORMATION**

*To evaluate all potential claims, it is very important for us to know about your family and dependents.*

Full name of spouse: \_\_\_\_\_

List all other names by which your spouse has ever been known. Include marital and maiden names, nicknames and aliases: \_\_\_\_\_

Date of marriage: \_\_\_\_\_ Place of marriage: \_\_\_\_\_

Have you ever been divorced or legally separated? Give details.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY INFORMATION continued**

List the names, ages and addresses of everyone including children who are dependent on you for support, and your relationship to each:

Name	Address	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**CLAIM INFORMATION**

Date of Injury or Collision/Incident: \_\_\_\_\_

Location of accident: \_\_\_\_\_

Describe what happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Names and addresses (if known) of other people involved:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT HISTORY**

Most recent employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Beginning Date of Employment: \_\_\_\_\_ Ending Date of Employment: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

Beginning pay rate: \_\_\_\_\_ per \_\_\_\_\_ Ending pay rate: \_\_\_\_\_ per \_\_\_\_\_

Did you miss time from work as a result of your injuries? \_\_\_\_\_

List the dates you were unable to work: From: \_\_\_\_\_ To: \_\_\_\_\_

Reasons for leaving job: \_\_\_\_\_

Employer prior to one last listed: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Beginning Date of Employment: \_\_\_\_\_ Ending Date of Employment: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

Beginning pay rate: \_\_\_\_\_ per \_\_\_\_\_ Ending pay rate: \_\_\_\_\_ per \_\_\_\_\_

Did you miss time from work as a result of your injuries? \_\_\_\_\_

List the dates you were unable to work: From: \_\_\_\_\_ To: \_\_\_\_\_

Reasons for leaving job: \_\_\_\_\_

Employer prior to one last listed: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Beginning Date of Employment: \_\_\_\_\_ Ending Date of Employment: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

Beginning pay rate: \_\_\_\_\_ per \_\_\_\_\_ Ending pay rate: \_\_\_\_\_ per \_\_\_\_\_

Did you miss time from work as a result of your injuries? \_\_\_\_\_

List the dates you were unable to work: From: \_\_\_\_\_ To: \_\_\_\_\_

Reasons for leaving job: \_\_\_\_\_

*Use additional sheets as necessary to provide past employers for previous 10 years*

**EDUCATION, TRAINING AND EXPERIENCE**

List your educational level (high school, college, graduate school, professional training): \_\_\_\_\_

\_\_\_\_\_

List any special job training: \_\_\_\_\_

\_\_\_\_\_

Have you been in the military? \_\_\_\_\_ Give service number: \_\_\_\_\_

Type of discharge: \_\_\_\_\_ Dates of service: \_\_\_\_\_

Have you had any service-connected injuries or disabilities? Give details. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Percentage of disability: \_\_\_\_\_ Do you receive payments for service-connected injuries? \_\_\_\_\_

Present condition of service-connected injury or disability: \_\_\_\_\_

\_\_\_\_\_

Have you ever been rejected for military service because of physical, mental or other reasons? If so, explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**POLICE RECORD**

*(The defense will investigate your background. We must be prepared against any unfavorable evidence that is uncovered. Evidence of prior criminal acts might be used against you at trial, no matter how mitigating the circumstances.)*

List all prior arrests.

**Date**                      **Place**                      **Charge**                      **Result**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PRIOR CLAIMS AND LAWSUITS**

*(Our adversaries will inquire about your history of legal claims and lawsuits. It is important that you disclose your complete history to us. It is not fatal if you have been involved in prior legal actions. You won't be penalized by a court or jury if the claims were reasonable and genuine.)*

List every claim you have ever made for personal injury or property damage. Give details.

Date of claim: \_\_\_\_\_ Nature of claim: \_\_\_\_\_

\_\_\_\_\_

Against whom: \_\_\_\_\_

Result: \_\_\_\_\_

Date of claim: \_\_\_\_\_ Nature of claim: \_\_\_\_\_

\_\_\_\_\_

Against whom: \_\_\_\_\_

Result: \_\_\_\_\_

Date of claim: \_\_\_\_\_ Nature of claim: \_\_\_\_\_

\_\_\_\_\_

Against whom: \_\_\_\_\_

Result: \_\_\_\_\_

*Use additional sheets as necessary to provide the above information for ANY claim or lawsuit ever filed*

**WORKERS' COMPENSATION**

Have you ever made a claim for workers' compensation? \_\_\_\_\_ When was the date of your injury? \_\_\_\_\_

What was your injury? \_\_\_\_\_

\_\_\_\_\_

Are you presently receiving payments? \_\_\_\_\_ Explain: \_\_\_\_\_

\_\_\_\_\_

Who is handling your workers' compensation action? \_\_\_\_\_

Are you receiving disability payments from any source other than workers' compensation? \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_



**ILLNESS OR DISEASE**

*(We must know about all prior illnesses, either before or since your accident. This is particularly true if there is any connection with your present physical complaints. The defendant will have access to a complete history of your past physical condition as well as your veteran's records, insurance records, and medical and hospital records.)*

Date: \_\_\_\_\_ Nature of illness: \_\_\_\_\_

Duration: \_\_\_\_\_ Treated by: \_\_\_\_\_

Hospitalized? \_\_\_\_\_ When: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

Date: \_\_\_\_\_ Nature of illness: \_\_\_\_\_

Duration: \_\_\_\_\_ Treated by: \_\_\_\_\_

Hospitalized? \_\_\_\_\_ When: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

Date: \_\_\_\_\_ Nature of illness: \_\_\_\_\_

Duration: \_\_\_\_\_ Treated by: \_\_\_\_\_

Hospitalized? \_\_\_\_\_ When: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

Date: \_\_\_\_\_ Nature of illness: \_\_\_\_\_

Duration: \_\_\_\_\_ Treated by: \_\_\_\_\_

Hospitalized? \_\_\_\_\_ When: \_\_\_\_\_

Name and address of hospital: \_\_\_\_\_

***Use additional sheets as necessary to provide information for illness of disease***

Do you now, or have you ever had trouble with: Ears: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hearing aid? \_\_\_\_\_

Have you ever worn glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_ Artificial eye? \_\_\_\_\_

Have you ever worn a brace or back and neck support? \_\_\_\_\_

Have you ever worked with radioactive substances, asbestos or any other substance alleged to cause diseases, such as cancer? \_\_\_\_\_

Have you ever been denied life or health insurance? \_\_\_\_\_

If so, by which company and why? \_\_\_\_\_

Have you ever been treated for alcoholism, drug addiction or venereal disease? \_\_\_\_\_

**THE INJURIES RESULTING FROM THIS INCIDENT**

*We need as much information as possible about the injuries you sustained in this incident*

State all injuries known to be a result of the accident:

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Length of time confined to bed: \_\_\_\_\_

Length of time confined to house: \_\_\_\_\_

State present physical condition, including scars, disabilities, deformities and discomforts due to the injuries

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List all physicians and surgeons you have seen:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

*Use additional sheets as necessary to provide information for each physician or surgeon*

List all nurses, therapists, chiropractors and other health care professionals that you have seen:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Nature of treatment: \_\_\_\_\_ Still under care? \_\_\_\_\_

*Use additional sheets as necessary to provide information for each health care provider*

**ADDITIONAL DOCUMENTS TO BRING WITH YOU**

\_\_\_\_\_ Copy of collision report or other documentation of incident

\_\_\_\_\_ Exchange of Driver Information form

\_\_\_\_\_ Insurance policies

\_\_\_\_\_ Physician, hospital and other medical provider bills

\_\_\_\_\_ Tax returns for last five years

\_\_\_\_\_ Any correspondence that you have received as a result of this incident