CONFIDENTIAL CLIENT INFORMATION FORM

This questionnaire is for the use of our office only in preparing your claim. Please answer every question fully and accurately because, as your attorneys, we must know all about your case. One surprise because of an incorrect or incomplete answer could cause you to lose your case. All of the questions are important even though they may not appear to have anything to do with your case. Please type or print all answers. Use additional sheets of paper or reverse side of this form, if needed.

CASE INFORMATION

YOUR NAME: _____

DATE OF INCIDENT:_____

YOUR INSURANCE COMPANY:_____

NAME AND ADDRESS OF OTHER PERSON:_____

OTHER PERSON'S INSURANCE COMPANY: _____

WAS A POLICE REPORT FILED? IF SO, PLEASE GIVE THE CASE NO. AND THE NAME OF THE POLICE AGENCY:_____

INFORMATION ABOUT YOU

1. What your full name?_____
2. Birthplace_____
3. Social Security No._____
4. Phone/Cell No._____
5. Address _____
6. Email Address_____
7. Date of Birth _____
8. Mother's Name_____ 9. Father's Name_____
10. Marital Status_____
11. If divorced, date and place_____
12. If spouse deceased, date of death_____
13. Name, address and age of all those (including children) who are dependent upon you for support, and your relationship to each:

Name Address Age Relationship

_____

_____

_____

14. List the address where you have resided during the past 10 years and give the period of time at each residence, including dates:

Address From To

_____

_____

_____

15. Have you ever used any other name?_____ If so, what?_____
Where?_____ Why?_____
16. Are you married at the present time?_____
Date of marriage:_____ Place:_____

WORK BACKGROUND

1. Present job: _____
2. Name, address ad phone number of employer:_____

_____

3. Present job title and duties:_____
4. How long have you worked at this job:_____
5. Your present pay:_____
6. If you were not working for this employer at the time of your accident, state the following regarding your then employer:
   a. Name of employer:_____
   b. Address of employer:_____
   c. Job title and type of work:_____
   d. Pay rate:_____
   e. Hours per week regularly worked:_____
   f. Date you began working for this employer:_____

g. Date you left this employer:_____

h. Reason for leaving employer:_____

7. What did you earn before your accident took place?_____

8. List prior employment for past five years:

Name	Address	Date employed	Job title

9. Is your spouse employed?_____ Employer's name and address_____

_____

Wages $_____ per_____ How long employed?_____

Average yearly income for spouse:_____

MEDICAL HISTORY BEFORE INCIDENT

1. Were you hospitalized at any time before the incident in this case? If so, list below all hospitalizations.

Date	Hospital	Doctor	Duration	Nature of Illness

2. Have you had any physical examinations before this incident? If so, list all physical examinations for five years before the incident.

Date	Place	Name of Doctor	Purpose

3. Have you had any accidents or injuries before this incident? If so, list every such accident or injury, whether there was a claim for damages or not.

Date	Place	Type of Accident	Treating Physician

4. Have you had any illness or disease before this accident? If so, list each and every illness or disease suffered in the five years before this accident.

Date	Nature of Illness	Duration	Treated By

5. Have you had any chronic health problems? If so, list them below.

6. Did you use any drugs regularly before the incident? If so, list the type and the reason.

7. Have you ever had any insurance of any kind declined or cancelled? If so, give reason.

8. Have you ever had any broken bones? If so, give date and circumstances.

9. List the normal activities, including sports, hobbies, or other activities you enjoyed before this accident.

MILITARY SERVICE, LAW ENFORCEMENT, AND PRIOR CLAIMS

1. Were you ever in the Military service? _____ If so list dates:_____
2. Type of discharge:_____
3. Any service-connected injuries?_____Details:_____
4. Have you received or do you receive payments form the V.A., Social Security or other source?_____ Claim No.:_____

FACTS OF ACCIDENT

1. Date:_____ Day:_____ Time:_____
2. Type of weather:_____
3. Did the accident occur during daylight, dusk or dawn?_____

4. Give exact location and describe what happened:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. Diagram:

North:_____

Indicate on a diagram in the space above what happened. Write in street or highway names or numbers and show direction of travel by arrows. Also, show north by putting an arrow in a circle.

FACTS CONCERNING THE DEFENDANT

1. Name of other party:_____

   Address:_____

   Phone No.:_____ DOB:_____
2. Insurance company:_____
3. Insurance adjuster:_____ Claim No.:_____
4. Insurance coverage:_____

5. Do you know what the other party's financial circumstances are without regard to any insurance he/she might have? If so, please specify:_____

_____

CLIENT'S INSURANCE

1. Name of your insurance company:_____

   Policy No.:_____
2. Have you filed a claim for this auto accident? If so, give the name of the adjuster and the claim no.:_____

   _____
3. Does your policy provide for medical payments to you? _____

   If so, give the amount. _____
4. Does your policy cover you if you are in a collision with someone who does not have insurance? _____
5. Do you have insurance covering damage to your car?_____

   If so, what is the deductible amount? _____
6. How much are you insured for if you hurt someone else with your automobile?_____

   _____
7. Do you have health or accident insurance?_____ If so, give the name of the company and the policy numbers:_____
8. Who is your insurance agent?_____

EDUCATION

1. Please give your educational background, listing names of schools attended, years attended, and any degrees obtained:_____

   _____

   _____

   _____

POLICE RECORD

1. Have you ever received a police ticket or been convicted of a crime? If so, list below.

Date	Place	Charges	Result

2. Is there now or has there ever been a restriction on your driver's license? _____

   Details of restriction: _____

   _____

CLAIMS AND LAWSUITS

Have you ever been involved in any claim or lawsuit, including divorce? List below every claim you have made for money or lawsuits you have ever been involved in.

Date	Place	Against Whom	Nature of Claim	Result

WITNESSES

List the contact information you have of all the witnesses to the accident (person who saw or may have seen the accident), and any other person who may be of assistance in testifying about your case, your injuries, or changes in your activities since the accident.

1. Name:_____
   Address:_____ Phone No.:_____
   What does he/she know?_____
2. Name:_____
   Address:_____ Phone No.:_____
   What does he/she know?_____
3. Name:_____
   Address:_____ Phone No.:_____
   What does he/she know?_____
4. Name:_____
   Address:_____ Phone No.:_____
   What does he/she know?_____

STATEMENTS MADE

1. Have you told any police officer, investigator, insurance adjuster or any other person about the collision? _____

2. Have you given any written statement to any person about the collision? _____ If so, please answer the following:

   a. Name of person to whom statement was given: _____

   b. Date statement was given: _____

   c. If written, do you have a copy? _____

   d. Persons present at the time statement given: _____

   e. Did you sign the statements? _____

3. Please give us any statement you know the defendant made about the accident, or that you understand he/she may have made: _____

   _____

   _____

4. When and where made: _____

5. Name and address of person who heard it: _____

   _____

DAMAGES FROM AUTOMOBILE ACCIDENT

The amount of recovery made in this case will be affected b the damages or expenses incurred as a result of your accident. It is important that you fully list all information regarding your injuries and your expenses as a result of this accident.

1. State, in full detail, all injuries received as a result of this accident: _____

   _____

   _____

2. State your present physical condition (e.g. scars, deformities, headaches, pains, etc.) due to injuries received in this accident: _____

   _____

   _____

3. Have you missed any time from work as a result of your injury? _____

If so, list the inclusive dates you were unable to work:

From: _____ To: _____
From: _____ To: _____
From: _____ To: _____
From: _____ To: _____

4. Did you lose wages for the periods of time missed from work due to this accident? _____

If so, explain: _____

_____

5. Have you had any increases or decreases in your pay since the accident? _____

If so, explain: _____

_____

6. List all hospitals in which you were examined or treated, or to which you were admitted as a patient as a result of the injuries sustained in the accident, the dates, and the total costs:

a. Hospital: _____
Address: _____
From: _____ To: _____
Total Costs: _____

b. Hospital: _____
Address: _____
From: _____ To: _____
Total Costs: _____

c. Hospital: _____
Address: _____
From: _____ To: _____
Total Costs: _____

7. List the full name, address, and telephone number of each physician or surgeon who has examined or treated you for your injuries as a result of the accident:

a. Doctor's Name: _____
Address: _____
Telephone Number: _____
Type of Treatment: _____

b. Doctor's Name:_____
Address:_____
Telephone Number:_____
Type of Treatment:_____

c. Doctor's Name:_____
Address:_____
Telephone Number:_____
Type of Treatment:_____

8. Have you used any of the following in connection with treatment?

Back or neck brace? _____	Dates: _____
Crutches?_____	Dates: _____
Traction?_____	Dates: _____
Physiotherapy?_____	Dates: _____
Other?_____	Dates: _____

9. List here all of your usual activities which you have not been able to perform, or can only perform with difficulty, since the accident, such as climbing stairs, ironing, cutting grass, dancing, lifting children, etc.

_____

_____

_____

10. Time lost from school in case of pupil: _____

11. Period you were confined to your house: _____

12. Please summarize your out-of-pocket expenses, and if you have not previously given us the name and address, indicate whom they are owed, as well as the amounts and whether they have been paid.

		Amount	Paid
a.	Physicians and surgeons:_____ _____	$_____	$_____
b.	Ambulance:_____	$_____	$_____
c.	Hospitals: _____	$_____	$_____
d.	Nurses:_____	$_____	$_____
e.	Prescriptions:_____	$_____	$_____
f.	Nonprescription medications:____ _____	$_____	$_____
g.	Crutches, braces, etc.:_____ _____	$_____	$_____

h.	X-rays:_____	$_____	$_____
i.	Domestic help:_____	$_____	$_____
j.	Auto repair:_____	$_____	$_____
k.	Car rental: _____	$_____	$_____
l.	Your lost wages:_____	$_____	$_____
m.	Lost wages of family members:____		
	_____	$_____	$_____
n.	Wrecking charges:_____	$_____	$_____
o.	Towing charges:_____	$_____	$_____
p.	Storage charges:_____	$_____	$_____
q.	Personal effects damages:_____	$_____	$_____
	_____	$_____	$_____
r.	Mileage expense for treatment:_____	$_____	$_____
s.	Babysitting costs:_____	$_____	$_____
t.	Physical Therapy:_____	$_____	$_____
u.	Other:_____	$_____	$_____
	TOTAL:	$_____	$_____

CONCLUSION

In completing this questionnaire, have you thought of any information which we have not asked which MAY be of some assistance to us in serving you? If so, please state it here no matter how silly, trivial, or embarrassing it may seem.

_____

_____

_____

_____

DATED this _____ day of _____, 20___.

_____

Client