Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

CLIENT INFORMATION SHEET

FULL NAME: ____

STREET ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP CODE: _________

HOME PHONE: ________________________ CELL PHONE: _______________________

OTHER PHONE: ______________________ E-MAIL____________________________

FACSIMILE: _________________________ WORK PHONE: ______________________

EMPLOYER: ____

STREET ADDRESS: ____

CITY: _____________________________ STATE: __________ ZIP CODE: __________

DATE OF BIRTH: ________________ SOCIAL SECURITY #: _________________

MARITAL STATUS: ___ MARRIED ___SINGLE ___WIDOWED ___DIVORCED

IF MARRIED, NAME OF SPOUSE: __________________________________

NAME, ADDRESS, AND PHONE NUMBER OF YOUR NEAREST RELATIVE THAT DOES NOT LIVE WITH YOU:

____

____

HOW DID YOU CHOOSE OUR BUSINESS?: _____________________________________

REFERRAL (BY WHOM?):____

DATE OF INCIDENT:____

LOCATION OF INCIDENT:____

PLEASE CHECK THE TYPE OF PROBLEM YOU WISH TO DISCUSS:

WORKER'S COMPENSATION: ___ INSURANCE: ___ ESTATE: ___ BANKRUPTCY: ___

PERSONAL INJURY (AUTO ACCIDENT, ETC.): ___ DEFECTIVE PRODUCT: ___

CONSUMER: ___ OTHER: ___

Document hosted at JDSUPRA™
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

HAVE YOU CONTACTED OR HAVE YOU BEEN UNDER CONTRACT WITH ANY OTHER ATTORNEY REGARDING THIS MATTER?:

___ NO ____ YES _____ PREVIOUSLY, BUT NOT AT THIS TIME

IF YOUR ANSWER WAS "**YES**" OR "**PREVIOUSLY**", PLEASE EXPLAIN:

____

____

IF THIS INVOLVES AN AUTOMOBILE ACCIDENT, WAS THERE AN INVESTIGATION BY LAW ENFORCEMENT? ___ YES ___ NO

AGENCY: _________________________ ACCIDENT REPORT#__________________

DO YOU HAVE A COPY OF THE REPORT? ___ YES ___NO

WERE YOU A DRIVER OR A PASSENGER? _________________________________

PLEASE LIST ANY ADDITIONAL OCCUPANTS IN YOUR VEHICLE:

NAME: ________________________ NAME: ___________________________

ADDRESS: ____________________ ADDRESS: ________________________

PHONE: _______________________ PHONE:__________________________

You may use the back of this form to list additional passengers, if needed.

WAS AN AMBULANCE CALLED TO ASSIST YOU? ___YES ___NO

YOUR AUTOMOBILE INSURANCE COVERAGE:

COMPANY:___________________________ POLICY#_____________________

DO YOU HAVE UNDERINSURED/UNINSURED MOTORIST COVERAGES?

___ YES ___ NO ___UNCERTAIN

DO YOU HAVE MEDICAL PAYMENTS THROUGH YOUR AUTO INSURANCE?

___ YES ___NO ___UNCERTAIN

DO YOU HAVE HEALTH INSURANCE COVERAGE? ___YES ___ NO

Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

IF "YES", PLEASE PROVIDE THE FOLLOWING:

NAME OF COMPANY: ____

POLICY #: ___________________________ GROUP ID#: ________________________

INFORMATION REGARDING THE OTHER PARTY:

NAME: ____

ADDRESS: ____

AUTO INSURANCE: ____

ADJUSTER AND CLAIM#: ____

YOUR VEHICLE:

WAS YOUR VEHICLE TOWED? ___ YES ___ NO

IF "YES", WHERE WAS YOUR VEHICLE TAKEN?:

____

ARE THERE PHOTOGRAPHS OR VIDEO OF YOUR VEHICLE, THE SITE OF THE INCIDENT, OR THE INCIDENT ITSELF? ___ YES ___NO ___ UNCERTAIN

PLEASE DESCRIBE EXACTLY WHAT HAPPENED:_______________________________________

____

____

____

____

____

____

____

Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

DATE: __________________ SIGNATURE:______________________________

Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

PLEASE LIST THE PAIN AND DIFFICULTIES THAT YOU ARE EXPERIENCING AS A RESULT OF THIS INCIDENT:____

____

____

____

____

____

____

PLEASE LIST ALL PRIOR INJURIES AND/OR ILLNESSES THAT AFFECT THE AREAS OF INJURY SUSTAINED IN THIS INCIDENT:

____

____

____

____

WORKER'S COMPENSATION: HAVE YOU EVER EXPERIENCED A WORK RELATED INJURY OR ILLNESS? ___YES ___ NO

IF "YES", PLEASE EXPLAIN: ____

____

____

____

ADDITIONAL HISTORY AND INFORMATION: ____

____

____

____

____

____

Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

PROVIDER LIST

Please list all of the healthcare providers that you have seen in regard to this incident. This includes ambulances, emergency rooms, hospitals, doctors, chiropractors, physical therapists, etc. If possible, please provide us with addresses, phone numbers, and dates of service. You may use the back of this form to list additional providers, if needed.

Primary Care Physician:

1.____

Ambulance(s):

1.____

2.____

Hospital(s) and/or Clinic(s):

1.____

2. ____

3.____

Physician(s) and/or Chiropractor(s) (M.D., D.O., D.C.):

1. ____

2. ____

3. ____

4.____

5.____

Physical Therapist(s) and any other healthcare providers:

1. ____

2. ____

3. ____

THIS PAGE INTENTIONALLY LEFT BLANK

Document hosted at JDSUPRA™
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f

THIS PAGE INTENTIONALLY LEFT BLANK

Document hosted at JDSUPRA™
http://www.jdsupra.com/post/documentViewer.aspx?fid=a97fefb3-f647-46cb-9555-416cd726281f