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Please print out and fill out the form below. Feel free to use additional pages if needed. For clarity, please label continuation responses according to section and item numbers.

PERSONAL INJURY INTAKE

OFFICE USE ONLY:
Accident Client Interviewed By: _____ Date: _____
Referral Source: _____ File No. _____

I. CLIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Date of Birth: _____ SSN: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____
Pager/Cell Phone: _____ E-mail: _____
☐ Spouse: ☐ Guardian: _____
Date of Birth: _____ SSN: _____
Child: _____ DOB: _____
Child: _____ DOB: _____
Critical Deadlines: _____
City/Public Authority Involved? ☐ YES ☐ NO
Notice of Claim Deadline: _____
Statute of Limitations: _____

II. EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Address: _____
Average Monthly Income: _____ Date Employment Commenced: _____
Average Work Day Length: _____ Average Work Week Length: _____
Supervisor: _____ Phone No.: _____
Last Day Worked Before Accident: _____
Date Returned: _____ Light/Restricted Duty? ☐YES ☐NO
Have you lost income due to injuries? ☐ YES ☐ NO
If yes, amount of lost income: $_____
Income before injury: $_____ per _____
Income after injury: $_____ per _____

III. EDUCATION

School Name: _____
Address: _____
Grade Level: _____

IV. ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____
Location Of Accident: _____
Client Was Traveling On What Street/Road: _____
Offending Vehicle Was Traveling On What Street/Road:_____
Weather: _____ Plaintiff's Position In Vehicle: _____
Accident Description: _____

_____

_____

_____

Precinct: _____ Accident No.:_____
Officer's Name: _____ Officer's Badge No.: _____

V. Diagram of Accident:

VI. WITNESSES

Witness #1 Name: _____
Address: _____
Phone Number: _____
Witness #2 Name: _____
Address: _____
Witness #3 Name: _____
Address: _____
Phone Number: _____
Witness #4 Name: _____
Address: _____
Phone Number: _____

VII. VEHICLE INFORMATION

☐ Our client was the _____ in vehicle # 1 (Owner/Operator/Passenger).
☐ Our client was a pedestrian.

Vehicle No. 1: (Vehicle transporting client – if applicable)
Vehicle Plate No.: _____ Vehicle's Year:_____
Vehicle's Make: _____ Vehicle's Model: _____
Vehicle's VIN #: _____
Owner's Name: _____
Owner's Address: _____
Leaseholder's Name: _____
Address: _____
Operator of Vehicle:_____
Address: _____
Carrier/Insurance Code:_____
Address: _____
Policy Holder: _____ Policy No.: _____
Effective Date of Policy: _____ Expiration Date of Policy: _____
Effective Date of Policy: _____ Expiration Date of Policy:

*****Please provide a copy of the police report (if on hand) as well as any citations received relevant to this accident.*****

VIII. Injuries

How did your injury occur?
☐ Aircraft accident
☐ Animal bite
☐ Assault/battery
☐ Defective premises
☐ Defective product
☐ Police negligence or abuse
☐ Motor vehicle accident
☐ Slip/trip and fall
☐ Water related accident
☐ Other:_____
Injuries Sustained:_____
_____
_____
_____
_____
Describe how your injuries occurred:_____
_____
_____
_____
_____
Where any other parties injured in this accident? ☐ YES ☐ NO
If other parties were injured, what was the scope of their injury?:_____
_____
_____
_____
Emergency Care at Scene? Ambulance: ☐ YES ☐ NO

_____

Are you currently in pain?: ☐ YES ☐ NO
If so, please describe:_____

Describe any other ways in which your life has changed as a result of your injuries. (For example, you are no longer able to engage in athletic activities, your appearance has changed, you cannot care for your children, etc.):_____

If married, has your spouse experienced any losses as a result of your injury? If so, describe:_____

IX. Hospitals

Hospital #1 (Immediately after accident):_____
Date Of Treatment: _____ Date Of Discharge: _____
Address: _____
Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

Hospital #2:_____
Date Of Treatment: _____ Date Of Discharge: _____
Address: _____
Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

Hospital #3:_____
Date Of Treatment: _____ Date Of Discharge: _____
Address: _____
Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

X. Physicians

1. Doctor's Name: _____Specialty:_____
Address: _____
Phone: _____ First Visit: _____
Currently treating with this physician? ☐ YES ☐ NO

2. Doctor's Name: _____Specialty:_____
Address: _____
Phone: _____ First Visit: _____
Currently treating with this physician? ☐ YES ☐ NO

3. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____
Currently treating with this physician? ☐ YES ☐ NO

4. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____
Currently treating with this physician? ☐ YES ☐ NO

5. Doctor's Name: _____ Specialty: _____
Address: _____
Phone: _____ First Visit: _____
Currently treating with this physician? ☐ YES ☐ NO

XI. Medical Bills

Approximate medical expenses incurred to date: _____
Future medical expenses expected: _____

XII. Prior Accidents

Has the client ever previously been involved in an automobile or any other type of accident? ☐ YES ☐ NO

If yes, complete the following:
DOA: _____ Place: _____
Description: _____
_____
_____
_____
Injuries Sustained: _____
_____
_____
_____
List the medical providers who rendered treatment: _____
_____
_____
Did the client commence a lawsuit? ☐ YES ☐ NO
If Yes, Please list the name and address of client's prior counsel: _____
_____

Date: _____ _____
Client Signature