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CLIENT QUESTIONNAIRE

Client's Name: _____

Today's Date: ____/____/____

Home Telephone:(____)____-_____

Work Telephone: (____)____-_____

Cell Phone (____) ____-_____

E-mail address: _____

This questionnaire is confidential and for the use of our office only, in preparing your claim. Please answer every question fully and accurately because we cannot properly represent or advise you unless we know all about you and your case. All of the questions are important and should be answered. Please type or print all answers. Use additional sheets of paper or reverse side of this form if needed.

Day of Week and Date of Accident: _____ ____/____/____

Time of accident _____ a.m. / p.m.

Place of accident: _____

Give exact location of accident, including names of streets, municipality, county and state.

Was your involvement in this accident as an OPERATOR (**circle one**) PASSENGER or PEDESTRIAN?

Name and address of all of your automobile insurance carrier(s):

All Policy No(s):

Do you reside with a relative who has his or her own separate motor vehicle insurance policy? If so, please state that person's name, his or her relationship to you, his or her insurance company, and policy number.

With regard to the vehicle you were operating or riding in as a passenger, state:

a. MAKE _____ MODEL _____ AND YEAR _____ OF VEHICLE.

b. Name and address of registered owner: _____

c. Name and address of operator: _____

d. Driver's License No. of operator: _____

e. Vehicle registration number: _____

f. Name and address of insurance company: _____

g. Insurance policy number: _____

h. Number of vehicles in your household: _____

i. Other vehicles: MAKE _____, MODEL _____ AND YEAR _____ OF VEHICLE.

MAKE _____, MODEL _____ AND YEAR _____ OF VEHICLE.

** Please attach the insurance policy and all insurance documentation for each vehicle (Declaration Sheet, Endorsements, Amendments, etc.).

j. Was accident reported to your insurance company? YES (**circle one**) NO If so, when and by what means?
_____.

**If additional vehicles were involved, please provide same information on separate sheet of paper.

Please describe in your own words how this accident happened. Include the direction each vehicle was travelling. Draw a diagram or sketch (on separate sheet of paper illustrating how the accident happened).

What were the weather conditions at the time of the accident?

What were the road conditions at the time of the accident?

What were the lighting conditions in the area of the accident?

Describe streets or highways involved stating:

- a. condition and width: _____
- b. lane markings: _____
- c. type of pavement: _____
- d. speed limit: _____
- e. traffic controls: _____

Were you using seat belts at the time of the accident? YES (circle one) NO

Are you aware of any defects existing in any of the vehicles prior to the accident? If so, describe fully:

Were any repairs done to the vehicle within one year prior to the accident? If so, discuss the nature of the repair and who performed the repair.

Describe location and nature of damage to each vehicle involved.

Were any photographs taken of the accident site, property damage to vehicles or victim's injuries (scars, bruises)?

** If so, please provide a print of each photo, state date taken and by whom.

What was the speed of each vehicle at the time of impact? _____

Did each vehicle involved have headlights on at the time of impact? YES (circle one) NO

Were any traffic citations or moving violations issued by the investigating police department?

YES (circle one) NO If yes, state type of citation and to whom issued.

Identify by name and address, if possible, passengers in each vehicle.

Were any skid marks left on roadway? YES (circle one) NO

If yes, please state:

- a. from which vehicle: _____
- b. length of mark: _____
- c. location on roadway: _____

State where each vehicle came to rest after impact.

Did you hear any horn blowing prior to impact? YES (circle one) NO

Where were you coming from and going to at the time of the accident?

If you were a passenger, where in the car were you sitting?

Was there anything in the immediate vicinity of the accident to obstruct anyone's view? YES (circle one) NO
If so, describe fully.

If you were a pedestrian, answer (a) through (f):

- a. Were you crossing at a designated crosswalk or an intersection? YES (circle one) NO
- b. Did you look in both directions before crossing? YES (circle one) NO
- c. Did you continue to look in both directions? YES (circle one) NO
- d. How far into the road had you walked prior to impact? _____
- e. Did you step from between parked cars? YES (circle one) NO
- f. Was there a pedestrian traffic control signal? YES (circle one) NO

How did you leave the scene of the accident? If by ambulance, state which company.

Where did you go immediately after the accident and who took you?

List all witnesses to the accident:

NAME and ADDRESS	PHONE	LOCATION DURING ACCIDENT	RELATIONSHIP TO YOU
	() -		
	() -		
	() -		
	() -		

List anyone who investigated the accident that caused your injuries. (police department, insurance investigator, etc.):

Did you give any Statements, written, recorded or phone, to anyone regarding the accident? YES (circle one) NO
 If so, state:

TO WHOM	DATE	TYPE OF STATEMENT	DO YOU HAVE A COPY?
	/ /		YES (circle one) NO
	/ /		YES (circle one) NO
	/ /		YES (circle one) NO

Were any offers of settlement made *prior* to your consulting our office? YES (circle one) NO
 If yes, state by whom, when and amount:

Have you consulted with any other attorney regarding this matter? YES (circle one) NO
 If yes, state with whom, when and results of that consultation:

PERSONAL INFORMATION:

Date of Birth: ___/___/___
 Social Security #: _____-_____-_____
 Driver's License #: _____
 Driver's License Limitation(s): _____
 Home Telephone: (____)____-____ Work Telephone: (____)____-____
 Marital Status: _____ Occupation: _____

SPOUSE:

Spouse's Full Name: _____
 Date of Birth: ___/___/___
 Social Security #: _____-_____-_____
 Driver's License #: _____
 Driver's License Limitations: _____
 Home Telephone: (____)____-____ Work Telephone: (____)____-____
 Occupation: _____

CHILDREN:

Name: _____ Age: _____
 Address: _____
 (if not residing with you)
 Name: _____ Age: _____
 Address: _____

(if not residing with you)

Name: _____ Age: _____

Address: _____

(if not residing with you)

EMPLOYER AT TIME OF ACCIDENT

Name: _____

Address: _____

Telephone: (____)____-_____

Immediate Supervisor: _____

Personnel Director: _____

Job Title: _____

Employed since: ____/____/____

Monthly Wages: _____ HOURLY / WEEKLY (**circle one**) MONTHLY / YEARLY

Any job change since the accident? YES (**circle one**) NO

If so, give details of present employment:

Name: _____

Address: _____

Telephone: (____)____-_____

Immediate Supervisor: _____

Personnel Director: _____

Job Title: _____

Employed since: ____/____/____

Monthly Wages: _____ HOURLY / WEEKLY (**circle one**) MONTHLY / YEARLY

Did you lose any time from work as a result of this accident? YES (**circle one**) NO

If so, state:

Amount of time lost: _____

Dates absent from work: ____/____/____ to ____/____/____

If still absent,
expected date of return: ____/____/____

Were you paid for absence: YES (**circle one**) NO

If yes, how were you paid and from whom were you paid? _____

Amount of wages lost: _____

If self-employed,
cost of hiring substitute: _____

Set forth any changes in your employment situation as a result of this accident. For example, are you performing lesser duties or are you performing duties only with assistance of a fellow employee?

Employment History of Past Ten (10) Years:

DATES OF EMPLOYMENT	EMPLOYER/ADDRESS	POSITION	SALARY
to / / / /			
to / / / /			
to / / / /			
to / / / /			

HOBBIES:

Sports participation and frequency:

Other recreational activities and frequency:

Church affiliation:

Membership in Organizations or service clubs:

MILITARY SERVICE:

Branch: _____ Rank: _____

Dates: _____ / _____ / _____ to _____ / _____ / _____

Duties: _____ Current Status: _____

Base address: _____

Award(s): _____

Type of Discharge: _____ Date of Discharge: _____ / _____ / _____

ARREST RECORD:

Date: _____ / _____ / _____ Places: _____

Charge: _____ Result: _____

Attorney /Address: _____

PRIOR MARRIAGES:

To Whom: _____

Date: ____/____/____

Where: _____

Date of divorce: ____/____/____

If former spouse is deceased, give date: ____/____/____

INCOME TAX:

If you filed a federal income tax return for the five (5) years prior to your accident, please attach those tax returns and all W-2 statements.

Accountant / Address: _____

PRIOR CLAIMS:

Have you ever made any previous claims for personal injury, property damage or filed a workmen's compensation claim? YES (circle one) NO

If so, please provide: Date: ____/____/____

Against whom: _____

Nature of claim: _____ Was suit filed? YES (circle one) NO

Attorney / Address: _____

MEDICAL HISTORY (before this accident):

List all prior injuries or illnesses whether or not hospitalization was necessary:

Medical Problem: _____

Dates: ____/____/____ to ____/____/____

Physician: _____

Hospital: _____

If you have not fully recovered from any of the above injuries or illnesses, state what problems or difficulties you have as a result of these prior injuries or illnesses.

FAMILY DOCTOR:

Name: _____

Address: _____

Telephone: (____)____-_____

How long have you been a patient of this physician? _____

How frequently do you see your family physician? _____

The date of your last visit: _____/_____/_____

Have you ever been treated for emotional distress and/or illness, narcotic addiction or alcoholism?

YES (circle one) NO If so, state:

Date: Facility: _____/_____/_____ _____

Physician: _____

Results: _____

Are you currently receiving treatment for injuries from the accident or treatment for emotional distress?

YES (circle one) NO

Date of last visit: _____/_____/_____

SUBSEQUENT INJURIES (after this accident):

If you have been injured in any way or contracted any illness since the accident which is the subject of this claim describe fully:

INJURIES (as a result of this accident):

List all injuries you sustained as a result of this accident and describe fully:

Do you have any disability from these injuries? YES (circle one) NO

If so, describe in detail and set forth the period of time you have been disabled.

Has a medical doctor told you that you have a disability? YES (circle one) NO

If so, when and what did he tell you?

Is it permanent? YES (circle one) NO

Will it get better? YES (circle one) NO

What were you able to do before the accident which you are not able to do now?

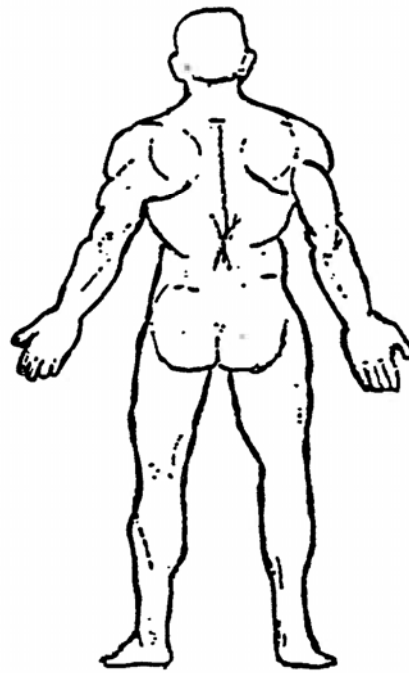
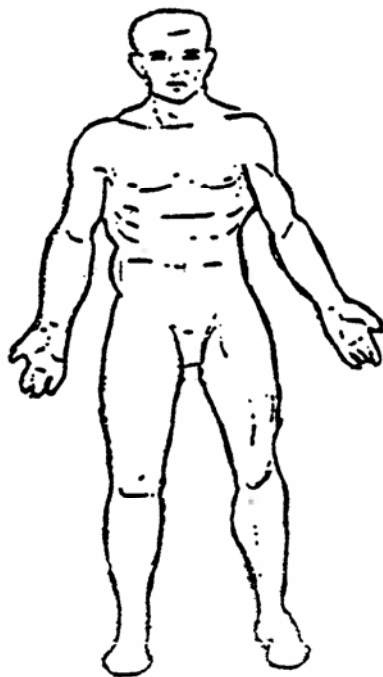
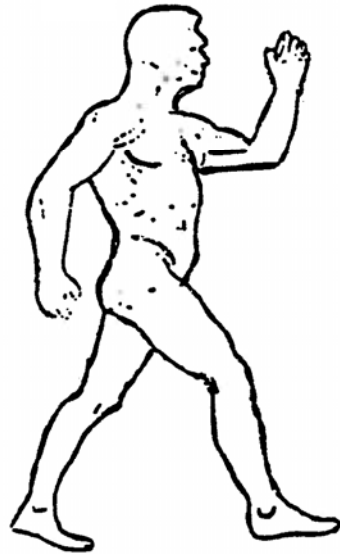
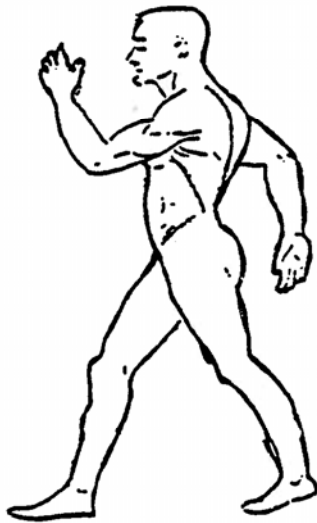
What were you able to do before the accident which you are able to do now, but not as well?

Give the names and addresses of all physicians, hospitals or health care providers who treated you for these injuries and attach any bills in your possession.

List any other expenses you have incurred as a result of your injury. Include such things as ambulance, household help, drugs or medical appliances and attach any documentation in your possession.

SHOW AREAS OF INJURY AND PAIN:

SHOW AREAS OF INJURY AND PAIN:



If you are still being treated for the above injuries, identify those individuals who are presently providing services.

Did you drink any alcohol or take any drugs or medications within 24 hours prior to this accident?

YES (**circle one**) NO

If so, state specifically what substance, how much was ingested, and the approximate times of ingestion:

Describe fully how injuries sustained have affected your activities of daily living and hobbies. For example, tiring easily, unable to ice skate, difficulty climbing stairs, etc.

List those people who can testify to your condition before and after you sustained injuries.

NAME AND ADDRESS	PHONE	RELATIONSHIP TO YOU
	() -	
	() -	
	() -	
	() -	

Thank you.

Your signature: _____