CLIENT INTERVIEW/QUESTIONNAIRE

DATE COMPLETED:_________________

THE FOLLOWING INTERVIEW/QUESTIONNAIRE IS FOR THE USE OF OUR OFFICE ONLY IN PREPARING AND EVALUATING YOUR CLAIM.

THE ANSWERS YOU GIVE HERE ARE FOR OUR USE ONLY IN HANDLING YOUR CLAIM. THE ANSWERS WILL BE HELD STRICTLY CONFIDENTIAL, AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS.

PLEASE ANSWER EVERY QUESTION FULLY AND ACCURATELY. ALL OF THE QUESTIONS ASKED ARE ***IMPORTANT***. IF MORE SPACE IS NEEDED, USE THE REVERSE SIDE OF THE PAGES.

CLIENT INTERVIEW/INFORMATION SHEET

I. **PERSONAL INFORMATION**

1. FULL NAME:____
2. ADDRESS: ____
   ____
   ____
3. TELEPHONE NUMBERS:
   A. HOME: ____________________________________
   B. WORK: ____________________________________
   C. CELL: ____________________________________
4. AGE: __________ DATE OF BIRTH: ____________________
5. SOCIAL SECURITY NUMBER:____________________________
6. MARITAL STATUS: (At time of accident): ______________________
   (Currently): ____________________________
   If married, Spouse's name:____________________________
   Spouse's D/Birth:____________________________
   Spouse's S.S. #:____________________________
7. OTHER NAMES KNOWN BY: (When and why):__________________
   ____
   ____
   ____
8. If client is a minor, the name, address, phone # of natural/legal guardian:______
   ____
   ____
9. DEPENDANTS:

NAME	ADDRESS (if different from yours)	AGE	RELATIONSHIP

10. HOW DID YOU HEAR ABOUT OUR OFFICE:_________________________

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II. ACCIDENT INFORMATION

11. ACCIDENT/INCIDENT DATE:_____________________________________

12. DAYS OF THE WEEK ACCIDENT OCCURRED:_______________________

13. TIME OF ACCIDENT/INCIDENT:_____________________________AM/PM

14. LOCATION OF THE ACCIDENT: (Be Specific)_________________________

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II A. AUTOMOBILE ACCIDENT

(If your case is not an auto accident, skip to section II B.)

15. DESCRIBE IN DETAIL HOW THE ACCIDENT HAPPENED: (Comment, if applicable, upon the following: actions taken by you to prevent the accident, defects in the road or car, distances, lanes of travel, intersection, horn sounds, radio on, windows up, air conditioning on, brake noise, tire squeal, skid marks, turn signals, guard rails, stop signs, street lights, road conditions, curves, center lane, curbs, hills, school zone, speed limits, pedestrians, witnesses, location of debris from car, statements, intoxication, medication, etc.:____

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16. WERE YOU WEARING A SEATBELT:________________________________

WHAT TYPE OF SEATBELT: (i.e. lap, shoulder, both):____________________

WAS THE CAR EQUIPPED WITH AIRBAGS:____________________________

IF YES, DID AIRBAGS DEPLOY:_________________________________

17. WERE YOU THE DRIVER OR A PASSENGER:___________________________

18. WERE YOU "ON THE JOB" AT THE TIME OF THE ACCIDENT, OR, ON YOUR WAY TO OR FROM WORK:_____________________________________

19. NAME AND ADDRESS OF THE DEFENDANT (Person at fault):___________

____

____

20. DEFENDANT'S INSURANCE COMPANY:_______________________________

____

21. HAS THE DEFENDANT'S INSURANCE COMPANY CONTACTED YOU:___

Adjuster's/Representative's name:____

Claim #, (if given to you):____

Phone #, (if given to you):____

Address, (if given to you):____

22. HAVE YOU GIVEN A "STATEMENT" TO THE DEFENDANT'S INSURANCE COMPANY:__________. WAS IT TAPE RECORDED:_____

23. DID YOU OWN THE MOTOR VEHICLE YOU WERE IN AT THE TIME OF THE ACCIDENT:____

IF SO, PLEASE COMPLETE THE FOLLOWING:

A. Your insurance company:____

B. Policy #:____

C. Have you reported the accident to your company:_____________________

D. Claim #:____

E. Please give the interviewer your insurance card and/or declaration sheet.

24. IF YOU **<u>DID NOT</u>** OWN THE MOTOR VEHICLE YOU WERE IN AT THE TIME OF THE ACCIDENT, PLEASE PROVIDE THE FOLLOWING:

A. Owner of the motor vehicle:______________________________________

B. Owner's Insurance Company:_____________________________________

C. Policy#:____

D. Have you reported the accident to owner's company:________________

E. Claim #:____

F. Please give the interviewer any insurance documents you may have regarding owner's policy.

25. DID A LAW ENFORCEMENT AGENCY RESPOND TO THE SCENE:______

Which Agency:____

26. WAS AN ACCIDENT REPORT COMPLETED:___________________________

DO YOU HAVE A COPY:_____________. (If yes, please give us a copy.)

27. DID PARAMEDICS RESPOND TO THE ACCIDENT SCENE:_____________

Which agency:____

28. WERE YOU TAKEN TO THE HOSPITAL:_____________________________

Which hospital:____

Were you admitted overnight, or released the same day:______________________

If admitted, how many days were you in the hospital:_________________

29. WAS YOUR VEHICLE DAMAGED:____________________________________

IF SO, PLEASE DESCRIBE THE DAMAGE TO YOUR VEHICLE:__________

____

____

30. HAVE YOU GOTTEN ESTIMATES OF REPAIR:________________________

If so, where did you get estimates from:___________________________________

____

31. HAVE YOU SETTLED YOUR PROPERTY DAMAGE:___________________

If so, how much was the settlement:______________________________________

Was the settlement with the defendant's company, or your own:_______________

32. DO YOU KNOW OF ANY WITNESSES TO THE ACCIDENT:_____________

If so, please provide their names, addresses and phone numbers:______________

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II B. SLIP/TRIP AND FALL (PREMISES LIABILITY) OR OTHER ACCIDENTS

(If your case is an auto accident, skip to section III.)

33. DESCRIBE IN DETAIL HOW THE ACCIDENT HAPPENED: (Comment, if applicable, upon the following: location of you, location of any witnesses, the area where the fall occurred, size of the material/area where fall occurred, statements made, appearance of material area where fall occurred, color of material, texture of material, smell of material, actions taken by you to prevent the accident, clean up, location of employees of premises, etc.:__________________

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34. WHAT TYPE OF SHOES WERE YOU WEARING AT THE TIME:__________

35. WERE YOU "ON THE JOB" AT THE TIME OF THE ACCIDENT, OR, ON YOUR WAY TO OR FROM WORK:__________________________________

36. NAME AND ADDRESS OF THE DEFENDANT (PERSON AT FAULT):_____

____

____

____

37. DEFENDANT'S INSURANCE COMPANY:____________________________

____

____

38. HAS THE DEFENDANT'S INSURANCE COMPANY CONTACTED YOU:

____

Adjuster's/Representative's name:____

Claim #, (if given to you):____

Phone #, (if given to you):____

Address, (if given to you):____

39. HAVE YOU GIVEN A "STATEMENT" TO THE DEFENDANT'S INSURANCE COMPANY:_____________. WAS IT RECORDED:__________

40. DID A LAW ENFORCEMENT AGENCY RESPOND TO THE SCENE:______

Which Agency:____

41. WAS AN ACCIDENT REPORT COMPLETED:___________________________

By Whom:____

42. DID PARAMEDICS RESPOND TO THE ACCIDENT SCENE:_____________

Which Agency:____

43. WERE YOU TAKEN TO THE HOSPITAL:______________________________

Which Hospital:____

Were you admitted overnight, or released the same day:______________________

If admitted, how many days were you in the hospital:_________________

44. DO YOU KNOW OF ANY WITNESSES TO THE ACCIDENT:_____________

If so, please provide their names, addresses and phone numbers:______________

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III. ADDITIONAL INSURANCE INFORMATION

SINCE IT IS POSSIBLE THAT THE PERSON THAT CAUSED YOUR INJURIES MAY NOT HAVE ADEQUATE INSURANCE TO COVER YOU DAMAGES, IT IS IMPERATIVE THAT YOU PROVIDE US ANY INSURANCE ISSUED TO YOU, SO THAT WE CAN EXHAUST ALL POSSIBILITIES OF PROVIDING YOU BENEFITS OR COVERAGE TO WHICH YOU ARE ENTITLED.

45. DID YOU OWN A MOTOR VEHICLE AT THE TIME OF THE ACCIDENT:____________________. IF SO, ANSWER THE FOLLOWING:
HOW MANY:____
INSURANCE COMPANY:____
POLICY #(S):____
____

46. DID ANYONE THAT LIVED WITH YOU AT THE TIME OF THE ACCIDENT OWN A MOTOR VEHICLE:_______________________________
IF SO, Name of person owning vehicle:___________________________
Their insurance company:_________________________________
Policy #:____

Name of person owning vehicle:___________________________
Their insurance company:_________________________________
Policy #:____

Name of person owning vehicle:___________________________
Their insurance company:_________________________________
Policy #:____

47. DO YOU HAVE ANY TYPE OF HEALTH INSURANCE COVERAGE, EITHER PERSONALLY, OR PROVIDED TO YOU THROUGH AN EMPLOYER:_______________. IF SO, ANSWER THE FOLLOWING:
Insured's name:____
Policy/Group #:____
Company name:____

48. ARE YOU PROVIDED HEALTH INSURANCE COVERAGE THROUGH ANY GOVERNMENT PROGRAM: (i.e. Medicare, Medicaid, etc.):__________

IF SO, Type of Coverage:____

Policy #:____

Other policy information:____

49. DO YOU HAVE ANY OTHER TYPE OF PERSONAL INSURANCE: (i.e. Homeowners, Group, Personal, etc.):____

IF SO, PROVIDE DETAILS:____

____

____

IV. MEDICAL INFORMATION

(IMPORTANT!!!IMPORTANT!!!IMPORTANT!!!)

NO MATTER HOW TRIVIAL AN ILLNESS OR INJURY, EITHER BEFORE OR SINCE YOUR ACCIDENT, WE MUST KNOW ABOUT IT!!! THIS IS PARTICULARLY IMPORTANT IF THERE IS ANY CONNECTION WITH THE PRESENT PHYSICAL COMPLAINTS. THE DEFENDANT WILL HAVE AVAILABLE AT THE TRIAL, BY MEANS OF MEDICAL AND HOSPITAL RECORDS, VETERAN'S RECORDS, INSURANCE RECORDS, ETC., A COMPLETE HISTORY OF YOUR PAST PHYSICAL CONDITION. TO PROPERLY REPRESENT YOU, WE MUST KNOW ALL THIS BEFORE THAT.

50. PLEASE LIST THE INJURIES WHICH YOU ARE CLAIMING THAT YOU HAVE SUSTAINED AS A RESULT OF THIS ACCIDENT. FOR EACH INJURY STATE THE PART OF YOUR BODY INJURED, AND THE PROBLEMS YOU EXPERIENCE AS A RESULT OF THAT INJURY.

PART OF THE BODY INJURED **RESULTING PROBLEMS**

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51. PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ANY MEDICAL PROVIDERS THAT YOU HAVE SEEN IN REGARDS TO THE INJURIES YOU HAVE SUSTAINED IN THIS ACCIDENT. (This should include EMS, Hospitals, Doctors, Imaging Facilities, Physical Therapy Facilities, Pain Management Facilities, etc.):

NAME	**ADDRESS**	**PHONE #**	**TYPE OF TREATMENT**

52. PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ANY MEDICAL PROVIDERS THAT YOU HAVE SEEN IN REGARDS TO **ANY TREATMENT, FOR AS FAR BACK IN TIME AS YOU CAN RECALL, FOR ANY REASON EITHER BEFORE OR AFTER THIS ACCIDENT (OTHER THAN THOSE LISTED ABOVE FROM YOUR INJURIES CLAIMED FROM THIS ACCIDENT). THIS INFORMATION SHOULD AT LEAST INCLUDE ALL MEDICAL TREATMENT YOU HAVE RECEIVED IN THE TEN (10) YEARS PRIOR TO YOUR ACCIDENT.** (This should include treatment for any condition, even general check-ups or physicals. Additionally, it should definitely include any treatment for any prior accidents or injuries. Include all EMS, Hospitals, Doctors, Radiology or Imaging Facilities, Physical Therapy Facilities, Pain Management Facilities, etc.)

NAME	**ADDRESS**	**PHONE #**	**TREATMENT**	**DATE/YEAR**

53. DO YOU WEAR GLASSES OR CONTACT LENSES:______________________

IF SO, Who prescribed them:____

When was your last eye exam:____________________________________

When are you required to wear them:_______________________________

54. DO YOU WEAR A HEARING AID:_____________________________________

IF SO, Who prescribed it/them:____

Which ear do you wear one in:_____________________________________

When was your last exam:____

55. DO YOU TAKE ANY DRUGS OR MEDICATIONS REGULARLY, EITHER NOW, OR BEFORE THE ACCIDENT:___________________________________

IF SO, Name(s) of drug or medication:____________________________________

Reason for taking:____

If prescription, who prescribed:____________________________________

56. HAVE YOU EVER BEEN DENIED LIFE OR HEALTH INSURANCE BECAUSE OF YOUR HEALTH:____

IF SO, Denying Company:____

Reason for denial:____

57. HAVE YOU EVER RECEIVED ANY TYPE OF MENTAL HEALTH TREATMENT OR COUNSELING:_______________________________________

IF SO, PLEASE GIVE DETAILS AND TREATING PHYSICIANS:__________

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58. HAVE YOU EVER HAD ANY TYPE OF "INJURY" **PRIOR TO** THIS ACCIDENT:____________. IF SO, PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EACH INJURY:

DATE/YEAR **TYPE OF INJURY** **HOW WERE YOU INJURED**

____

____

____

____

59. HAVE YOU EVER HAD ANY TYPE OF "INJURY **SINCE** THIS ACCIDENT: ____________. IF SO, PLEASE COMPLETE THE FOLLOWING FOR EACH INJURY:

DATE/YEAR **TYPE OF INJURY** **HOW WERE YOU INJURED**

____

____

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____

____

V. WORK/EMPLOYMENT HISTORY

THE AMOUNT OF YOUR RECOVERY WILL BE AFFECTED BY YOUR LOST EARNINGS AND LOSS OF EARNING CAPACITY, SO PLEASE OUTLINE YOUR WORK BACKGROUND CAREFULLY.

60. WERE YOU EMPLOYED AT THE TIME OF YOUR ACCIDENT:__________

IF SO, Employer's name:____

Employer's Address:____

____

____

Employer's Phone #:____

Date you started working there:__________________________________

Number of hours per week:_______________________________________

Wage/Salary:____

Are you still employed with this company:__________________________

Describe your job, include your duties and responsibilities, as well as any special skills:____

____

____

____

61. HAVE YOU MISSED ANY TIME FROM YOUR JOB AS A RESULT OF THE INJURIES YOU SUSTAINED IN THIS ACCIDENT:______________________

IF SO, Dates you missed work:_____________________________________

62. DID A DOCTOR ORDER YOU TO NOT WORK AS A RESULT OF YOUR ACCIDENT:________________. IF SO, WHICH DOCTOR(S):_____________

____

63. IF YOU ARE NO LONGER EMPLOYED SINCE THIS ACCIDENT, PLEASE DESCRIBE WHY AND GIVE DETAILS:______________________________

____

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____

64. PLEASE PROVIDE A LIST OF YOUR FORMER EMPLOYERS FOR THE LAST TEN (10) YEARS, OR ANY ADDITIONAL EMPLOYERS **SINCE THE ACCIDENT**, GIVING FOR EACH THE FOLLOWING INFORMATION:

Dates employed Company Location Job Description Reason for Leaving

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____

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65. HAVE YOU EVER BEEN DECLARED OR FOUND DISABLED, OR UNABLE TO WORK, FOR ANY REASON:____________________________

IF SO, PLEASE GIVE DETAILS, INCLUDING DATE OF DISABILITY, AGENCY/COMPANY DECLARING YOU DISABLED, AND REASON FOR DISABILITY:____

____

____

____

66. HAVE YOU FILED UNITED STATES INCOME TAX RETURNS IN THE LAST FIVE (5) YEARS:____

IN WHICH YEARS DID YOU FILE:__________________________________

____

67. IF YOU ARE RETIRED, PLEASE DESCRIBE THE TYPE OF WORK YOU DID PRIOR TO RETIREMENT, YOUR AVERAGE ANNUAL INCOME, THE YEAR IN WHICH YOU RETIRED, THE COMPANY YOU RETIRED FROM, AND THE REASON YOU RETIRED:________________________________

____

____

____

____

____

VI. EDUCATION

YOUR EDUCATIONAL BACKGROUND WILL HAVE AN IMPORTANT BEARING UPON YOUR CASE BY ALLOWING US TO PROPERLY CALCULATE DAMAGES TO WHICH YOU ARE ENTITLED.

68. DID YOU GRADUATE HIGH SCHOOL:____________________________

IF SO, PLEASE GIVE THE SCHOOL NAME, LOCATION/ADDRESS, YOUR NAME IN HIGH SCHOOL, AND YEAR YOU GRADUATED:____________

____

____

IF NOT, HAVE YOU OBTAINED A GED:____________________________

IF YOU DO HAVE A GED, PLEASE PROVIDE WHERE YOU RECEIVED THE GED AND YEAR YOU RECEIVED IT:__________________________

____

____

69. PLEASE LIST THE FOLLOWING INFORMATION FOR ANY COLLEGE TRAINING, VOCATIONAL TRAINING, OR OTHER EDUCATIONAL COURSES YOU HAVE STUDIED:

COLLEGE	LOCATION	COURSES	DEGREE	DATE

70. PLEASE LIST ANY OTHER SPECIAL TRAINING YOU MAY HAVE RECEIVED; WHERE YOU RECEIVED IT; AND WHEN YOU RECEIVED IT:

TYPE OF TRAINING **RECEIVED AT** **DATES**

____

____

____

____

VII. MILITARY BACKGROUND

71. HAVE YOU EVER SERVED IN ANY BRANCH OF THE MILITARY:_______

IF SO, Which branch did you serve in:___________________________________

When did you start service:____

When did you end your service:____

What type of discharge:____

Were you ever injured (either in training, duty, or combat), and if so, give the details:____

____

____

____

Were you given a disability, and if so, please give percentage:___________

Do you receive any payments in connection to your service in the military, either through retirement or through disability, and if so, give details:____

____

____

____

____

VIII. PRIOR CLAIMS OR LAWSUITS

MANY CASES/CLAIMS HAVE BEEN DAMAGED BEYOND REPAIR BY CLIENTS FAILING TO DISCLOSE PRIOR CLAIMS OR LAWSUITS. THE DEFENDANT'S INSURANCE COMPANIES HAVE ACCESS TO INFORMATION THAT *WILL FIND* A CLAIM IF YOU HAVE EVER MADE ONE. FAILURE, ON YOUR PART, TO TELL US ABOUT OTHER CLAIMS OR LAWSUITS COULD CAUSE US TO NOT RECEIVE FULL VALUE FOR YOUR CLAIM, OR COULD CAUSE THE DEFENSE TO REFUSE TO SETTLE WITH LITIGATION. *THIS INFORMATION IS TERRIBLY IMPORTANT!!!*

72. HAVE YOU EVER BEEN INVOLVED IN ANY PRIOR CLAIMS OR LAWSUITS RELATED TO AN INJURY SUSTAINED BY YOU, OR RELATED TO DAMAGES SUSTAINED BY YOU OR YOUR PROPERTY:_______________. IF SO, FOR EACH CLAIM LIST:

DATE	AGAINST	NATURE OF CLAIM	SUIT?	RESULT

73. HAVE YOU EVER HAD ANY WORKER'S COMPENSATION CLAIM:_____ IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DATE	EMPLOYER	NATURE OF CLAIM	SUIT?	RESULT

74. HAVE YOU EVER HAD ANY INVOLVEMENT IN ANY OTHER TYPE OF LEGAL MATTER, HEARING, OR LAWSUIT, NO MATTER WHAT TYPE OF CASE (This includes divorces, custody hearings, business matters, etc.):________________. IF SO, PLEASE PROVIDE THE FOLLOWING:

DATE MATTER PARTIES COURT FILED IN RESULT

____

____

____

____

IX. ACTIVITIES

WARNING!!! WITH THE FILING OF A CLAIM FOR INJURIES, IT IS POSSIBLE THAT THE OPPOSING SIDE WILL GET SURVEILLANCE OF YOU. THIS COULD INCLUDE PHOTOS OR VIDEOTAPE OF YOU ON ANY GIVEN DAY. IF YOU ARE CLAIMING YOU CANNOT PERFORM A CERTAIN ACTIVITY, AND YOU ARE PHOTOGRAPHED DOING THAT ACTIVITY, IT WILL HURT YOUR CASE BY MAKING YOU LOOK UNTRUTHFUL. THEREFORE, PLEASE ACCURATELY COMPLETE THE FOLLOWING:

75. PLEASE LIST ALL ACTIVITIES YOU PERFORMED PRIOR TO THIS ACCIDENT, GIVING FOR EACH THE FOLLOWING INFORMATION: (This should include work related activities, home activities, and social activities. For example, lifting or physical things at your job, chores around your home, and/or your social entertainment, like bowling, fishing, hunting, etc.):

ACTIVITY WHERE PERFORMED FREQUENCY/ACTIVITY

____

____

____

____

____

____

____

76. PLEASE LIST ALL ACTIVITIES ABOVE WHICH YOU CAN NO LONGER PERFORM OR WHICH YOU ARE LIMITED IN, SINCE YOUR ACCIDENT, GIVING FOR EACH THE FOLLOWING INFORMATION:

ACTIVITY EFFECT OF INJURY FREQUENCY OF ACTIVITY NOW

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____

____

____

____

____

____

XI. OTHER DAMAGES YOU HAVE SUSTAINED

IN A CLAIM, THERE ARE MANY DAMAGES WHICH WE CAN RECOVER FOR YOU, WHICH YOU MAY NOT KNOW ABOUT OR THINK OF, THEREFORE, PLEASE COMPLETE THE FOLLOWING SECTION ACCURATELY.

77. ARE YOU CLAIMING THAT YOU HAVE LOST ANY WAGES OR EARNINGS AS A RESULT OF YOUR INJURIES:_________________. IF SO, PLEASE LIST:

DATES WAGES LOST FROM APPROXIMATE AMOUNT

____

____

____

____

78. HAVE YOU HAD TO HIRE A NURSE OR OTHER MEDICAL PROFESSIONAL TO PROVIDE YOU HOME HEALTH CARE AS A RESULT OF YOUR INJURIES:_____________. IF SO, PLEASE PROVIDE THE FOLLOWING:

DATES PERSON HIRED SERVICES PERFORMED AMOUNT

____

____

79. HAVE YOU HAD TO PURCHASE, OR HAVE YOU BEEN GIVEN A PRESCRIPTION TO PURCHASE, ANY MEDICAL OR REHABILITATIVE EQUIPMENT FOR YOUR HOME AS A RESULT OF YOUR INJURIES IN THIS ACCIDENT:_________________. IF SO, PLEASE PROVIDE THE FOLLOWING:

DATE EQUIPMENT PRESCRIBED PERSON PRESCRIBING AMOUNT

____

____

____

____

80. HAVE YOU HAD TO HIRE ANYONE TO HELP YOU PERFORM ANY DOMESTIC ACTIVITIES WHICH YOU CANNOT PERFORM AS A RESULT OF YOUR INJURIES:________________. IF SO, PLEASE PROVIDE THE FOLLOWING:

DATES PERSON HIRED FUNCTION PERFORMED AMOUNT PAID

____

____

____

____

81. DID YOU HAVE ANY OTHER PERSONAL BELONGINGS WHICH WERE DAMAGED OR LOST IN YOUR ACCIDENT (i.e. clothing, jewelry, glasses, equipment, etc.):______________. IF SO, PLEASE PROVIDE THE FOLLOWING:

ITEM DAMAGED HOW IT WAS DAMAGED APPROX. VALUE

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