DATE: ___________

SLIP & FALL

INTAKE BY: ___________

AUTO ACCIDENT

PERSONAL INJURY

FULL NAME:____

IF MINOR PARENTS= NAMES:____

HAVE YOU EVER USED OR BEEN KNOWN BY ANY OTHER NAME THAN THAT SHOWN ABOVE?_____ IF SO, PLEASE LIST EACH SUCH NAME, INCLUDING WHEN AND WHY YOU

USED IT.____

____

HOME ADDRESS:____

CITY:_________________________ STATE:________________ ZIP CODE:___________

HOME#:____________________________CELL#:___________________________

E-MAIL:________________________________ WORK#:______________________________

SSN:______________________________DOB:____________________________________

WHERE WERE YOU BORN?____

DRIVER LICENSE NO. & STATE:____

NAME, ADDRESS, & TELEPHONE NUMBER OF EMERGENCY CONTACT: _____________

____

MARITALSTATUS:________________SPOUSE:________________Anniversary:_________

IF SEPARATED, GIVE DATE OF SEPARATION:_____________________________________

LIST ALL DEPENDENTS, INCLUDING NAMES, AGE AND RELATIONSHIP:

____

____

EMPLOYMENT INFORMATION

WERE YOU EMPLOYED AT THE TIME OF ACCIDENT?_______________________________

EMPLOYER=S NAME:____

EMPLOYER=S ADDRESS:____

JOB TITLE:____

JOB DUTIES:____

RATE OF PAY:$_________ ( )HOURLY ( )WEEKLY ( ) BI-WEEKLY ( ) MONTHLY ( ) YEARLY

HOW OFTEN DO YOU WORK? _____ HOURS PER DAY _____ DAYS A WEEK (____-____)

LENGTH OF EMPLOYMENT:____

IF LESS THAN 13 WEEKS PRIOR TO ACCIDENT, PROVIDE PRIOR EMPLOYMENT INFORMATION AS REQUESTED ABOVE:____

____

____

HAVE YOU LOST TIME FROM WORK?____

DATE DISABILITY BEGAN:_______________ DATE DISABILITY ENDED:________________

TO DATE, HOW MUCH INCOME HAVE YOU LOST FROM WORK?_____________________

WORKERS COMPENSATION

AT THE TIME OF THE ACCIDENT, WERE YOU IN THE COURSE AND SCOPE OF YOUR EMPLOYMENT? _____ IF YES, WHAT WERE YOU DOING?____________________________

HAS A WORKERS COMPENSATION CLAIM BEEN FILED?_______________ WHAT IS THE NAME/ADDRESS/CLAIM NUMBER FOR YOUR WORKERS COMPENSATION CARRIER?

____

ACCIDENT/INCIDENT

DATE:______________________________ TIME:_______________________________

PLACE OF ACCIDENT:____

CITY:___________________________ COUNTY:_________________ STATE:_____________

DAYLIGHT/DARKNESS:______________________ WEATHER:_________________________

WHERE WERE YOU COMING FROM AND WHERE WERE YOU GOING TO?_____________

____

____

PROVIDE A DETAILED ACCOUNT OF HOW THE INCIDENT OCCURRED:_______________

____

____

____

____

____

____

____

____

____

____

____

____

PLEASE LIST ALL WITNESSES: NAMES, ADDRESSES & TELEPHONE NUMBERS:

____

____

____

AUTOMOBILE ACCIDENTS ONLY

WERE YOU DRIVER OR PASSENGER:______________ HOW MANY IN VEHICLE?_______

IF YOU WERE THE PASSENGER, WHO WAS DRIVING?_____________________________

WAS A LAW OFFICER CALLED TO THE SCENE?_____ WHAT DEPARTMENT?__________

WAS AN ACCIDENT REPORT MADE?________ ACCIDENT REPORT NO.:______________

WERE YOU QUESTIONED BY THE POLICE?_______________________________________

WERE PICTURES TAKEN AT THE SCENE OF THE ACCIDENT?_______________________

BY WHOM?_________________________ WHEN?__________________________________

WERE YOU WEARING A SEAT BELT AT THE TIME OF THE ACCIDENT?________________

WHAT WAS THE YEAR, MAKE, AND MODEL OF THE VEHICLE YOU WERE IN?__________

_____________________________ WHO OWNED THE VEHICLE?_____________________

PROPERTY DAMAGE:$__________________ WAS VEHICLE TOTALED?_______________

HAS PROPERTY DAMAGE BEEN SETTLED?_______ CLIENT NEEDS HELP:____________

DO YOU NEED A RENTAL CAR?____

HAVE PHOTOGRAPHS BEEN TAKEN OF PROPERTY DAMAGE?____________________ BY

WHOM?__________________________ WHEN?_________________________________

WHERE IS YOUR VEHICLE LOCATED?____

DESCRIBE PROPERTY DAMAGE TO YOUR VEHICLE: ___MILD ___MODERATE ___SEVERE
DESCRIBE PROPERTY DAMAGE TO OTHER VEHICLE:___MILD___MODERATE___SEVERE
NOTE: PLEASE PROVIDE YOUR ATTORNEY WITH THE PROPERTY DAMAGE/VALUATION ESTIMATE, REPAIR BILLS, AND RECEIPTS.

PIP / UM INSURANCE INFORMATION

NAME OF YOUR AUTOMOBILE INSURANCE COMPANY: ____________________________

POLICY HOLDER: ______________________POLICY NUMBER: _______________________

CLAIM #:_____________________________ PHONE #:_________________________________

HAS PIP APPLICATION BEEN SENT TO YOUR INSURANCE COMPANY? _______________

PIP DEDUCTIBLE? ____AMT:$_________MEDICAL PAYMENTS? _______AMT:$ _________

UM COVERAGE? _____AMT:$ _______COLLISION?________DEDUCTIBLE?____________

DID YOU PROVIDE A RECORDED STATEMENT TO THE INSURANCE COMPANY?_______

WHEN?_________________________ TO WHOM?________________________________

NUMBER OF MOTOR VEHICLES IN YOUR HOUSEHOLD: ____________________________

DESCRIBE ANY MOTOR VEHICLES THAT YOU OWNED AT THE TIME OF THE ACCIDENT (INCLUDING YEAR, MAKE AND MODEL): ____

____________________________________WERE THESE VEHICLES OPERABLE?________

DESCRIBE ALL MOTOR VEHICLES OWNED BY RELATIVES YOU RESIDE WITH ON THE DATE OF THE ACCIDENT:

RELATIVES NAME __________________VEHICLE ______________INS. CO. ____________

RELATIVES NAME __________________VEHICLE ______________INS. CO. ____________

DOES ANYONE IN YOUR HOUSEHOLD USE A COMPANY VEHICLE? __________________

____

DO YOU HAVE A CAR YOU BRING HOME FROM WORK? ____YES ____NO

AT FAULT DRIVER / OWNER INSURANCE INFORMATION

AT FAULT DRIVER'S NAME:____

AT FAULT DRIVER'S ADDRESS:____

AT FAULT OWNER'S NAME (if different from driver):_____________________________

AT FAULT OWNER'S ADDRESS:____

AT FAULT OWNER'S INSURANCE COMPANY:_____________________________________

TELEPHONE NUMBER:____

POLICY NUMBER:________________________ CLAIM NUMBER:______________________

AT FAULT DRIVER'S INSURANCE COMPANY:_____________________________________

TELEPHONE NUMBER:____

POLICY NUMBER:________________________ CLAIM NUMBER:______________________

DID YOU PROVIDE A STATEMENT TO THESE INSURANCE COMPANIES? ___________

WHICH COMPANY?___________________________ WHEN?_________________________

DID AT FAULT DRIVER HAVE A BUSINESS SIGN ON VEHICLE? ☐ YES ☐ NO.

WHAT WAS THE NAME ON THE SIGN:____

PREMISES LIABILITY INCIDENTS ONLY

PROPERTY OWNER=S NAME & ADDRESS:____

____

PROPERTY OWNER=S INS. CO.:____

POLICY NUMBER:______________________ CLAIM NUMBER:________________________

WAS AN INCIDENT REPORT FILED?____ DO YOU HAVE A COPY OF THE REPORT?_____

DID YOU SIGN THE INCIDENT REPORT?_____ DID YOU PROVIDE AN ORAL OR WRITTEN STATEMENT?_____ WHEN?_______________ FOR WHOM?_________________________

WERE PICTURES TAKEN OF THE SCENE OF THE ACCIDENT?_______________________

BY WHOM? ______________________ WHEN?______________________________________

HEALTH INSURANCE INFORMATION

CARRIER'S NAME:____________________________ MEMBER:_______________________

GROUP NO.:__________________________ CONTRACT NO.:_________________________

MEDICAID NO.:________________________ MEDICARE NO.:_________________________

INJURIES/TREATMENT

HEAD: □ LOC □ LAC □ CONCUSSION □ HEADACHE

NECK : □ PAIN □ SWELLING

BACK: □ PAIN □ UPPER □ MID □ LOWER

R-ARM/SHO: □ NUMBNESS □ TINGLING □ RADIATING PAIN

L-ARM/SHO: □ NUMBNESS □ TINGLING □ RADIATING PAIN

R-LEG/BUTT: □ NUMBNESS □ TINGLING □ RADIATING PAIN

L-LEG/BUTT: □ NUMBNESS □ TINGLING □ RADIATING PAIN

OTHER: ____

HOW DID YOU LEAVE THE SCENE OF ACCIDENT:______________________

HOSPITALS AT WHICH YOU HAVE TREATED FOR THIS ACCIDENT

NAME/ADDRESS OF HOSPITAL:____

DATE ADMITTED:______________________ DATE DISCHARGED:____________________

NATURE OF TREATMENT:____

****

NAME/ADDRESS OF HOSPITAL:____

DATE ADMITTED:______________________ DATE DISCHARGED:____________________

NATURE OF TREATMENT:____

PHYSICIANS/SURGEONS WITH WHOM YOU HAVE TREATED

NAME/ADDRESS OF PHYSICIAN:____

NATURE OF TREATMENT:____

DATE CARE BEGAN:______________________ STILL UNDER CARE?__________________

****

NAME/ADDRESS OF PHYSICIAN:____

NATURE OF TREATMENT:____

DATE CARE BEGAN:______________________ STILL UNDER CARE?__________________

****

NAME/ADDRESS OF PHYSICIAN:____

NATURE OF TREATMENT:____

DATE CARE BEGAN:______________________ STILL UNDER CARE?__________________

OUT OF POCKET EXPENSES/OBLIGATIONS YOU ARE CLAIMING

PLEASE PROVIDE A LISTING OF ALL DEBTS/CHARGES OWED OR PAID AS A RESULT OF THIS ACCIDENT, INCLUDING PRESCRIPTIONS, TOWING, HOSPITAL BILLS, ETC. __________

____

PAST MEDICAL HISTORY

□ NECK DX:________________________ DR:________________________

□ BACK DX:________________________ DR:________________________

□ ARMS DX:________________________ DR:________________________

□ LEGS DX:________________________ DR:________________________

□ SURG. DX:________________________ DR:________________________

□ CHRONIC DX:________________________ DR:________________________

□ PSYCH DX:________________________ DR:________________________

□ OTHER DX:________________________ DR:________________________

PRIOR ACCIDENTS/INJURIES AND CLAIMS/LAWSUITS

FAILURE TO MENTION OTHER ACCIDENTS/INJURIES OR CLAIMS/LAWSUITS CAN UNDERMINE A LAWSUIT, NO MATTER HOW TRIVIAL THEY MAY SEEM.

□ ACCIDENTS (A/A, S&F, ETC.)

TYPE:________________________

WHEN:________________________

WHERE:________________________

INJURY:________________________

DR/HOSP:________________________

RESULT:________________________

□ WORKERS COMP. CLAIMS

TYPE:________________________

WHEN:________________________

WHERE:________________________

INJURY:________________________

DR/HOSP:________________________

RESULT:________________________

□ INJ. TO SAME BODY PART

TYPE:________________________

WHEN:________________________

WHERE:________________________

INJURY:________________________

DR/HOSP:________________________

RESULT:________________________

□ SUBSEQUENT INJURY/ACCIDENTS

TYPE:________________________

WHEN:________________________

WHERE:________________________

INJURY:________________________

DR/HOSP:________________________

RESULT:________________________

HOBBIES / INTERESTS

WHAT ARE YOUR HOBBIES OR AREAS OF INTEREST?______________________________

____

LIST ALL ACTIVITIES THAT HAVE BEEN ELIMINATED OR HAMPERED AS ARESULT OF YOUR INJURIES, SUCH AS MOWING THE LAWN, HOUSEHOLD CHORES, DANCING, SPORTS, SLEEPING, ETC. ____

____

____

____

MILITARY BACKGROUND

HAVE YOU EVER SERVED IN THE MILITARY?______ BRANCH:_______________________

DATES OF SERVICE:__________________________ TO _______________________________

RANK/RATE:_________________________ TYPE OF DISCHARGE:______________________

CURRENT DUTY STATION ADDRESS:____

EDUCATIONAL BACKGROUND

HIGHEST GRADE/LEVEL COMPLETED:____

ANY SPECIAL EMPLOYMENT/SKILLS TRAINING:____________________________________

HOW DID YOU HEAR ABOUT OUR FIRM?

TELEVISION ________ RADIO________ PHONE BOOK_________ BILLBOARDS______

NEWSPAPER_______ FRIEND/RELATIVE________________ PHYSICIAN_______________

INTERNET______________

OTHER (EXPLAIN)____

Investigator: **Date:**

Overview Worksheet

Client Name:

Case Type:

Best Treating Location:

Synopsis of Accident:

Insurance Info (Coverage Info if Available):

Client:

AFD:

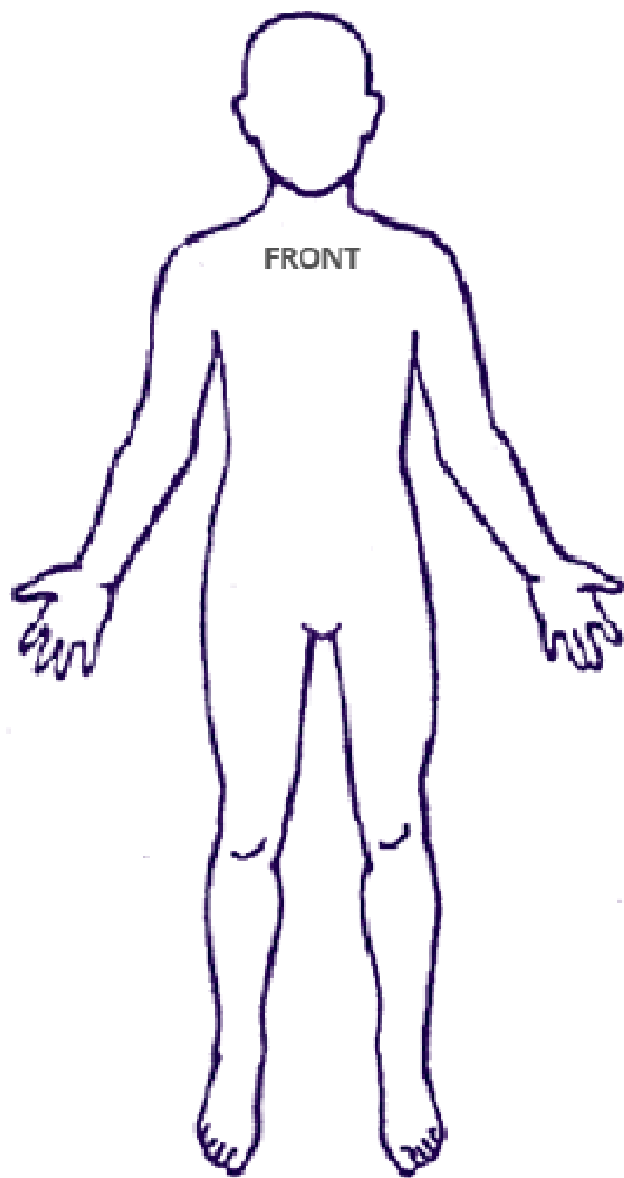
Special Details/Urgent Requests:

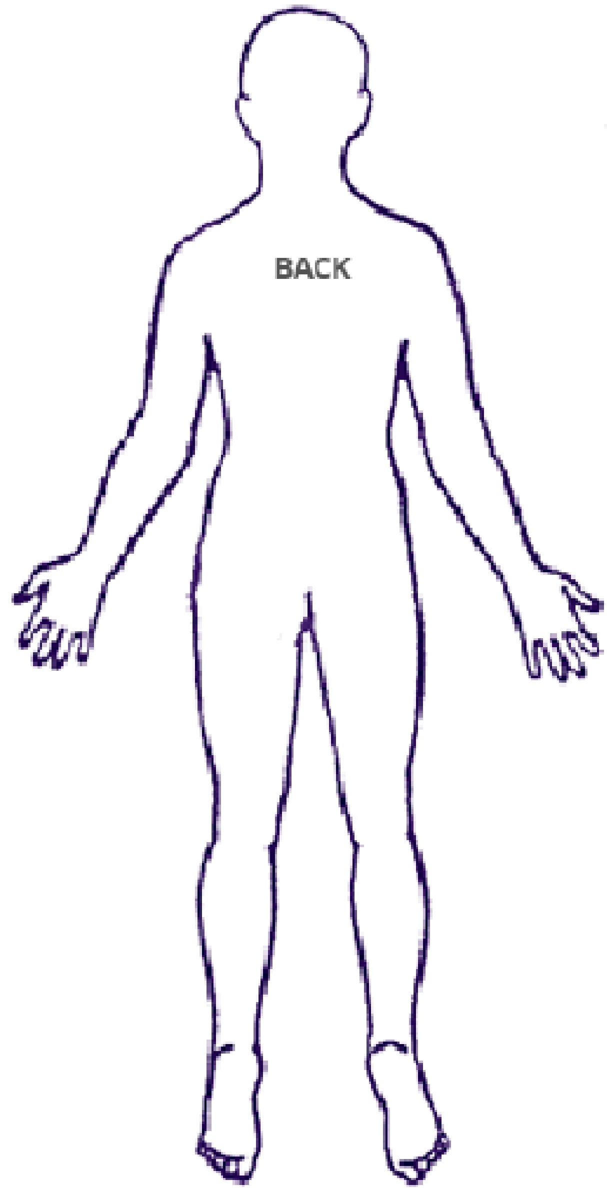
Photograph: Y/N **Photograph Type: PD / Scene / Client**

Notes:

File Assignment:

ON THE DIAGRAM, PLEASE CIRCLE OR PLACE AN X
ON THE PART(S) OF YOUR BODY THAT WAS INJURED





PLEASE DRAW ON THE DAGRAM HOW YOUR ACCIDENT OCCURRED

Use the diagram to reconstruct the locations of the cars and witnesses. Show the direction of travel of all the vehicles, the location of traffic signals and signs and any other makings or characteristics of the scene.