

SOL: \_\_\_\_\_  
DATE OF ACCIDENT/LOSS: \_\_\_\_\_

**PERSONAL INJURY  
INTAKE SHEET**

**INITIAL CLIENT STATEMENT**

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE? \_\_\_\_\_

IF SO, PLEASE GIVE NAME OF ATTORNEY: \_\_\_\_\_

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? \_\_\_\_\_

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)

\_\_\_\_\_

**PERSONAL INFORMATION:**

NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (home) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Email Address: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (work) \_\_\_\_\_

Occupation: \_\_\_\_\_ Worked there how long? \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

**SPOUSE'S NAME:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (home) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Telephone Number: (work) \_\_\_\_\_ Occupation: \_\_\_\_\_

Age: \_\_\_ Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Email Address: \_\_\_\_\_

**CHILDREN:**

Name(s)/Age(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many children are living with you now? \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**EDUCATION:**

High School/G.E.D.: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Technical School: \_\_\_\_\_

College/University: \_\_\_\_\_ Years & Degree: \_\_\_\_\_

**EMPLOYMENT HISTORY:**

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Duties: \_\_\_\_\_

\_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Prior **similar injuries**, treated medical conditions and/or symptoms to same area or current injury  
(Dates/Drs.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prior **claims and/or settlements** (types, dates, attorneys): \_\_\_\_\_  
\_\_\_\_\_

List any **prior injury settlements**: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACCIDENT INFORMATION:**

Accident Date: \_\_\_\_\_ Date of Week: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Location: (Be Specific) \_\_\_\_\_  
\_\_\_\_\_

Where were you? \_\_\_\_\_



What was said? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To whom? \_\_\_\_\_

Were photographs taken of the scene? \_\_\_\_\_

**INSURANCE COVERAGE FOR PLAINTIFF:**

Name of Carrier: \_\_\_\_\_

Carrier's Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Agent's Name, Address and Phone No.: \_\_\_\_\_

\_\_\_\_\_

Have you received any correspondence from your insurance company: \_\_\_\_\_

Deductible Amount: \_\_\_\_\_

Liability Coverage: \_\_\_\_\_

Medical Payment Amount: \_\_\_\_\_

Is this a WORKER'S COMP CLAIM? \_\_\_\_\_

Are you covered through your employer's insurance? \_\_\_\_\_

If so, provide company and agent, if known: \_\_\_\_\_

Policy or plan number: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Limits of coverage: \_\_\_\_\_

Did you file a claim with your insurance company? \_\_\_\_\_

Has anyone from the insurance company contacted you about this claim? \_\_\_\_\_

Name of Person who contacted you: \_\_\_\_\_

When was contact made? \_\_\_\_\_

If a statement was given, was it tape recorded or written? \_\_\_\_\_

Did you receive a copy? \_\_\_\_\_

Have you signed any authorizations to release information to anyone? \_\_\_\_\_

If so, identify: \_\_\_\_\_

Have you signed any releases? \_\_\_\_\_

If so, for whom? \_\_\_\_\_

Have you received any insurance benefits? \_\_\_\_\_

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? \_\_\_\_\_

If so, which agency? \_\_\_\_\_

**INSURANCE COVERAGE FOR DEFENDANT:**

Name of Carrier: \_\_\_\_\_

Carrier's Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Agent's Name, Address and Phone No.: \_\_\_\_\_

\_\_\_\_\_

Collision coverage amount: \_\_\_\_\_

Deductible Amount: \_\_\_\_\_

Liability Coverage: \_\_\_\_\_

Medical Payment Amount: \_\_\_\_\_

Uninsured Motorist Coverage Amount: \_\_\_\_\_

**MEDICAL INFORMATION:**

Were you injured in this accident? \_\_\_\_\_ Describe: \_\_\_\_\_

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Did you go to the hospital? \_\_\_\_\_

Which hospital? \_\_\_\_\_

Admitted or Out Patient? \_\_\_\_\_

If admitted, release date: \_\_\_\_\_

X-Rays taken? \_\_\_\_\_ Were you taken by ambulance? \_\_\_\_\_

Are you under the care of a physician now? \_\_\_\_\_

**LIST DOCTORS:**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

4. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

5. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_\_\_

Current Balance on Medical Bills: \_\_\_\_\_

**PRESCRIPTIONS:** BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR, CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING, OR WHEN CAST IS REMOVED.

**Was anyone else injured?** \_\_\_\_\_

Who was injured? \_\_\_\_\_

Describe Injury: \_\_\_\_\_

\_\_\_\_\_

**NAME AND ADDRESS OF ALL PARTIES INVOLVED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**WITNESSES:**

1. NAME & ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.):

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What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_\_\_

2. NAME & ADDRESS: \_\_\_\_\_

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Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.):

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What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_\_\_

3. NAME & ADDRESS: \_\_\_\_\_

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Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.):

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What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_\_\_

4. NAME & ADDRESS: \_\_\_\_\_

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Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.):

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What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_\_\_

5. NAME & ADDRESS: \_\_\_\_\_

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Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.):

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What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_\_\_

**VIEWING THE SCENE:**

Can we go to the accident scene? \_\_\_\_\_

Who do we contact to arrange a viewing? \_\_\_\_\_

NAME & ADDRESS: \_\_\_\_\_

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Telephone Number: (\_\_\_\_) \_\_\_\_\_

Job Title: \_\_\_\_\_

Can we photograph the scene? \_\_\_\_\_

Any other information you feel may assist us in representing you for this claim? \_\_\_\_\_

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**DAMAGES:**

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): \_\_\_\_\_

Sports: \_\_\_\_\_

Social Activities: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Household Chores: \_\_\_\_\_

Have you had to hire domestic help? \_\_\_\_\_

How do you feel you have been damaged emotionally by these injuries? \_\_\_\_\_

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How do you feel you have been damaged financially by these injuries? \_\_\_\_\_

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