PERSONAL INJURY/AUTO ACCIDENT
INTAKE FORM

HAVE YOU SPOKEN TO ANTOHER ATTORNEY ABOUT THIS CASE? ___ YES ___ NO

IF SO, PLEASE GIVE NAME OF ATTORNEY: _____

DO YOU HAVE A SINGED RELEASE BY THAT ATTORNEY? ___ YES ___ NO

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

DATE OF ACCIDENT:_____

S.O.L.:_____

CLIENT INFORMATION:

Client's Name:_____

Client's Address:_____

_____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____Age: _____

D.O.B.: _____ SS# _____

Employer: _____

Address: _____

Work Phone: _____ Ext.:_____

Fax: _____ Work Days/Hours: _____

How long have you worked there? _____

Immediate Supervisor: _____

Spouse's Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____ Occupation: _____

Client's Employer: _____ Occupation: _____

Duties: _____
_____

Client's Employer: _____ Occupation: _____

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

Date of Accident: _____ Day of Week: _____ Time: _____ am/pm

Where: (Be Specific) _____

_____

Where were you coming from? _____

Where were you going? _____

DETAILS OF ACCIDENT:

Weather condition (if happened outside): _____

Any construction in the area? _____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC – GET AS MUCH DETAIL AS POSSIBLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did this injury occur when you were driving a vehicle? ___ Yes ____ No

Were you driving a company vehicle? ___ Yes ____ No

What was the make, model and year of the vehicle you were driving? _____

_____

Was anyone, including yourself, to the best of your knowledge, taking any medications or using any sort of drugs? ___ Yes ____ No

If so, please list _____

_____

_____

_____

_____

Had anyone, including yourself, been drinking? ___ Yes ____ No

Did anyone make a statement at the scene? ___ Yes ____ No

If so, who? What was said?

_____

_____

_____

_____

_____

To whom? _____

Were photographs taken of the scene? _____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: _____

Address: _____

_____

Phone: _____

Agent's Name: _____

Address: _____

_____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Cash Policy for Accidents: _____

Effective Dates of coverage: _____

Is this a WORKE'S COMP CLAIMS? _____

Are you covered through your employer's insurance? ___ Yes ____ No

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? ___ Yes ____ No

Has anyone from the insurance company contacted you about this claim? ___ Yes ____ No

If yes, 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? ___ Yes ____ No

Have you signed any authorizations to release information to anyone? ___ Yes ____ No

If so, identify: _____

Have you signed any releases? ___ Yes ____ No

If so, for whom? _____

Have you received any insurance benefits? ___ Yes ____ No

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? ___ Yes ____ No

If so, which agency? _____

INSURANCE COVERAGE FOR DEFENDANT

Name of Carrier: _____

Address: _____

_____

Phone: _____

Agent's Name: _____

Address: _____

_____

Phone: _____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

MEDICAL INFORMATION:

Were you injured in this accident? ___ Yes ____ No

If so, please describe:

_____

_____

_____

_____

_____

Did you go to the hospital? ___ Yes ____ No

If so, which hospital: _____

Admitted or Outpatient? _____

If admitted, release date: _____

X-Rays taken? ___ Yes ____ No

Were you taken by ambulance? ___ Yes ____ No
(If City of Chicago ambulance, please sign authorization for release form)

Are you under the care of a physician now? ___ Yes ____ No

Did you miss work due to the accident? ___ Yes ____ No
(If yes, please

LIST DOCTORS:

1. Name: _____ Phone: _____

   Address: _____

   _____

   Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? ___ Yes ____ No

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? ___ Yes ____ No

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? ___ Yes ____ No

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? ___ Yes ____ No

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? ___ Yes ____ No

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? ___ Yes ____ No

Who was injured? _____

Describe the injury: _____

_____

_____

NAME AND ADDRESSES OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WITNESSES:

1. Name and address: _____

   _____

   Telephone Number: (____) _____

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

   What did each see? _____

   Would they be willing to testify in court to what he/she saw? ___ Yes ____ No

2. Name and address: _____

   _____

   Telephone Number: (____) _____

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

   What did each see? _____

   Would they be willing to testify in court to what he/she saw? ___ Yes ____ No

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   _____

   Telephone Number: (____) _____

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   Telephone Number: (____) _____

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

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ____ No

5. Name and address: _____

_____

Telephone Number: (____) _____

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

What did each see? _____

Would they be willing to testify in court to what he/she saw? ___ Yes ____ No

VIEWING THE SCENE:

Can we go to the accident scene? ___ Yes ____ No

Is the equipment available for inspection? ___ Yes ____ No

Who do we contact to arrange a viewing? _____

NAME AND ADDRESS: _____

_____

Telephone Number: (____) _____

Job Title: _____

Can we photograph the equipment? ___ Yes ____ No

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

_____

_____

_____

_____

_____

_____

_____

DIAGRAM OF HOW ACCIDENT OCCURRED:

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? ___ Yes ____ No

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

_____

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

_____

_____

_____