

DALE APPELL

PERSONAL INJURY LAW

CLIENT INTAKE AND CASE INFORMATION QUESTIONNAIRE (PREMISE LIABILITY)

PARTY

DATE: _____

LEGAL NAME: _____

SEX: _____ DOB: _____ SSN: _____

NICKNAME: _____

ADDRESS: _____

PHONE: _____ (HOME)

_____ (FAX)

_____ (OFFICE)

_____ (E-MAIL)

_____ (CELL/OTHER)

MARITAL STATUS: MARRIED DIVORCED SINGLE SEPARATED DOMESTIC PARTNER WIDOW/ER
(CIRCLE ONE)

SPOUSE'S NAME (IF APPLICABLE): _____

YOUR FORMER NAME(S): _____

DEPENDENTS/AGES: _____

PRIOR ACCIDENTS: _____

EMERGENCY CONTACT NAME (SOMEONE NOT IN YOUR CURRENT HOUSEHOLD): RELATIONSHIP: _____

TELEPHONE NUMBER: _____

ADDRESS: _____

DO YOU HAVE ANY PLANS TO FILE FOR BANKRUPTCY IN THE NEAR FUTURE? YES NO

HAVE YOU EVER BEEN ARRESTED? YES NO (IF YES, PLEASE EXPLAIN) _____

CASE

DATE OF INCIDENT: _____
PROVIDE A BRIEF DESCRIPTION OF WHAT OCCURRED: _____

LOCATION OF INCIDENT: _____
CITY: _____ COUNTY: _____ TIME: _____

INCIDENT SCENE INFO: _____

LIGHTING CONDITIONS: _____

FLOORING CONDITIONS: _____

DESCRIBE WHAT TYPE OF SHOES YOU WERE WEARING: _____

DESCRIBE WHAT CLOTHING YOU WERE WEARING: _____

DID YOU SIGN ANY WAIVER OR RELEASE? YES NO
DO YOU HAVE A COPY? YES NO

WAS AN INCIDENT REPORT TAKEN? YES NO IF YES, BY WHOM?: _____
DO YOU HAVE A COPY? YES NO

WERE THERE ANY WITNESSES TO THE INCIDENT? YES NO IF YES, WHOM?: _____

WHAT INFORMATION WOULD THESE WITNESSES HAVE?

CONTACT INFO FOR WITNESSES: _____

HAVE YOU PROVIDED A RECORDED STATEMENT TO ANY INSURANCE COMPANY? YES NO
IF YES, TO WHOM?: _____

DO YOU HAVE HEALTH INSURANCE/MEDICARE/MEDICAID? YES NO
NAME OF CARRIER: _____ (WE WILL NEED A COPY OF YOUR CARD)

INSURANCE

NAME OF DEFENDANT'S CARRIER: _____
ADDRESS: _____

CONTACT NUMBER: _____

ADJUSTER NAME: _____

CLAIM NUMBER: _____

LIMITS OF COVERAGE: GENERAL LIAB (GL): \$ _____

MED PAY: \$ _____

VALUE

HAVE YOU INCURRED ANY OUT-OF-POCKET EXPENSES AS A RESULT OF THIS INCIDENT? YES NO

IF YES, PLEASE DESCRIBE TYPE AND AMOUNT:

(PRESCRIPTIONS, CO-PAYS, DEDUCTIBLES)

\$ _____

\$ _____

EMPLOYMENT

CURRENT EMPLOYER: _____

POSITION: _____

ADDRESS: _____

NAME OF SUPERVISOR: _____

RATE OF PAY: _____ PER HOUR PER WEEK PER MONTH PER YEAR

HAVE YOU LOST WAGES DUE TO YOUR INJURIES IN THIS INCIDENT? YES NO

IF YES, HOW MUCH?: _____

MEDICAL

PROVIDE THE NAMES AND ADDRESSES OF ALL MEDICAL PROVIDERS YOU HAVE SEEN FOR YOUR INJURIES:

NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:	NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:
NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:	NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:

GENERAL HEALTH

PRIOR TO THIS INCIDENT, WHAT WAS THE STATE OF YOUR HEALTH (HIGH BLOOD PRESSURE, DIABETES, ETC.)?

NAMES OF TREATING PHYSICIANS: _____

WERE YOU TAKING ANY MEDICATIONS REGULARLY PRIOR TO THIS INCIDENT? YES NO

IF YES, PLEASE NAME THEM: _____

HAVE YOU HAD ANY PRIOR INJURIES? YES NO IF YES, PLEASE DESCRIBE: _____

INJURIES

PLEASE DESCRIBE ANY INJURIES TO ANY OF THE FOLLOWING PARTS OF YOUR BODY AND HOW OFTEN YOU FEEL PAIN. DESCRIBE WHAT THE PAIN FEELS LIKE. (IF YOU HAVE NO INJURY, PLEASE WRITE NONE)

HEAD: _____

JAW/MOUTH: _____

NECK: _____

SHOULDERS: R L BOTH _____

UPPER BACK: _____

ARMS: R L BOTH _____

HANDS: R L BOTH _____

CHEST: _____

TORSO: _____

ANY PROBLEMS WITH INTERNAL ORGANS?: _____

MID BACK: _____

HIPS: R L BOTH _____

LOW BACK: _____

LEGS: R L BOTH _____

FEET: R L BOTH _____

ANY OTHER SYMPTOMS OR PROBLEMS: _____

WERE YOU HOSPITALIZED? YES NO HAVE YOU HAD AN MRI? YES NO

HAVE YOU TAKEN PHOTOS OF YOUR INJURIES? YES NO DO YOU HAVE ANY SCARRING? YES NO

HAVE YOU PURCHASED OR WERE YOU PROVIDED ANY MEDICAL SUPPLIES? YES NO IF, YES: _____

HAVE YOU HAD ANY INJURIES SINCE THIS INCIDENT? YES NO IF YES, PLEASE DESCRIBE: _____

HOW HAS THIS INCIDENT AFFECTED YOUR PERSONAL LIFE [HOBBIES, RELATIONSHIPS, ETC.]? _____