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PERSONAL INJURY INTAKE SHEET

Date Form Completed: _____

DATE OF ACCIDENT: _____

TYPE: Auto/ Premises/ Medical Malpractice/ Other

Location: VA/MD/DC

PERSONAL INFORMATION:

Client's Name _____ Aliases _____

Address _____

Phones (CELL) _____

(WORK) _____

SSN _____ Race: _____ Sex: _____ Age: _____

DOB: _____

Married? M [] S [] D [] Resides With: _____

Emergency Contact: _____

EMAIL ADDRESS: _____

EMPLOYMENT INFORMATION:

Have you lost time from your employment because of this accident? Yes No

Name of Employer: _____

Address of Employer: _____

Dates Missed from Work: _____

Salary: _____

DEFENDANT INFORMATION

Name _____ Aliases _____

Address _____

Phones (CELL) _____

(WORK) _____

SSN _____ Race: _____ Sex: _____ Age: _____

DOB: _____

INSURANCE INFORMATION - CLIENT:

Name of automobile insurance company: _____

Claim Number: _____

Policy Number: _____

Adjuster's name: _____

Adjuster Phone Number: _____

Adjuster Address: _____

Property Damage:

Amount of Property Damage? \$ _____

Do you have insurance covering damage to your car? _____

Deductible amount: \$ _____

How much does your insurance cover if you hurt someone else with your car? \$ _____

INSURANCE INFORMATION – DEFENDANT

Name of automobile insurance company: _____

Claim Number: _____

Policy Number: _____

Adjuster's name: _____

Adjuster Phone Number: _____

Adjuster Address: _____

FACTS OF THE ACCIDENT:

Date: _____ Day: _____ Time: _____

Weather conditions: _____

Location: _____

Police Report case number: _____

Describe what happened:

DIAGRAM:

Indicate on a diagram in the space below what happened. Write in street or highway names or numbers and show direction of travel by arrows. Also, show north by putting an arrow in a circle:

OTHER INJURED PARTIES:

Were other parties, other than the defendant, injured in this accident? _____ If so, indicate the following:

Name of 2nd injured party: (2nd plaintiff): _____

Street address: _____ Telephone number: _____

City, state, zip: _____ Birthdate: _____

Relationship to you: _____

Name of 3rd injured party: (3rd plaintiff): _____

Street address: _____

Telephone number: _____

City, state, zip: _____ Birthdate: _____

Relationship to you: _____

WITNESSES TO THE ACCIDENT:

List the names, addresses, and telephone numbers of all witnesses to the accident, and any other persons who may be of assistance in testifying about your case, your injuries or changes in your activities since the accident:

Name of 1st witness: _____

Address: _____ Telephone: _____ Age: _____

Nature of testimony: _____

Name of 2nd witness: _____

Address: _____ Telephone: _____ Age: _____

Nature of testimony: _____

Name of 3rd witness: _____

Address: _____ Telephone: _____ Age: _____

Nature of testimony: _____

TREATMENT

Ambulance: _____

Hospital: _____

Medical Providers:

INSTRUCTIONS TO CLIENT

- 1. Do not talk to insurance adjuster;**
- 2. Do not discuss the facts of the accident with anyone before having your first conference with the attorney;**
- 3. Do not sign anything without your attorney's permission;**
- 4. Keep a diary of your trips to all doctors, hospitals, therapists and notes of your pain with times and dates;**
- 5. Keep all your medicine bottles and containers (as possible evidence at trial);**
- 6. Bring or send all future medical bills to attorney's office;**
- 7. When you return to treating physicians for follow- up examinations, be sure to advise them at each examination the nature of all of your continuing problems resulting from the accident;**
- 8. Keep a record of all out-of-pocket expenses, including travel expenses for medical treatment;**
- 9. Report to your attorney any suspicious actions, such as someone taking pictures, movies, etc.**

Out of Pocket Expenses

Client: _____

DOCTOR BILLS

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL DOCTOR BILLS	\$ _____

DRUGS

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL DRUG BILLS	\$ _____

HOSPITAL

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL HOSPITAL BILLS	\$ _____

PROPERTY DAMAGE

_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL PROPERTY LOSS	\$ _____

EARNINGS LOSS

_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL EARNINGS LOSS	\$ _____

OTHER LOSS

_____	\$ _____
TOTAL OTHER LOSS	\$ _____

TOTAL OUT OF POCKET LOSS	\$ _____
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