Intake Questionnaire

For Office Staff Only:

Referred By: _____ Date of Accident: _____

Case Type: _____ Time of Accident: _____

****

Name: _____ DOB _____

Address:

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

DL: _____ Social Security: _____

Marital Status: _____ Email: _____

Accident Information

Date Of Accident: _____

Explanation of Accident:

_____

_____

_____

_____

Street and/ Or Intersection of Accident: _____

Police: Yes___ or No____

Police Department: _____ Report# _____

Citation Issues: Yes ____or No _____

Who Received the Citation? _____

Defendant Driver Name: _____

Defendant Driver License Number: _____ State _____

Defendant Insurance Information:

Company: _____

Policy Number: _____ Claim# _____

Adjuster: _____ Phone# _____

Fax # _____ Email: _____

Your Vehicle:

Driver: _____

Were there any Passengers: Yes____ or No___

Please list all passengers and their phone numbers:

_____
_____
_____
_____

Injury Information:

Injuries:

_____
_____
_____
_____

Do you have any prior injuries or disabilities?

_____
_____
_____
_____

Health Insurance:

Company: _____ Group Number: _____

Policy # _____ Do you have Medicaid?: Yes___ or No___

Do you have Medicare?: Yes____ or No ____

Employment Information:

Employer Name: _____

Lost of Income: Yes ____or No _____

Rate of Pay: _____ Hourly___ Weekly___ Monthly____ Bi-Weekly____

Your Vehicle Information:

Year: _____ Make: _____ Model: _____
Damages: _____

Vehicle Location: _____

Your Insurance Carrier: _____

Policy Number: _____ Claim Number: _____

Adjuster _____ Phone# _____

Email: _____ Fax: _____

Defendant Vehicle Information:

Year: _____ Make: _____ Model: _____
Damages: _____

IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Father: _____ Telephone: _____
Mother: _____ Telephone: _____

PASSENGERS/COMPANIONS (if applicable): (other people in your car who were injured):

NAME _____

Contact Number: _____

_____

Address City State/Zip Code

Date of birth: _____

Social Security Number: _____

Driver's License: _____

Spouse's Name, if Married:_____

INJURIES:

_____

_____

_____

_____

Did above go to the hospital? Yes ____ No _____

Name of hospital: _____

Transported by ambulance? Yes ____ No _____

Name of ambulance service: _____

Did they take x-rays? Yes_____ No _____

IS ABOVE SEEING A DOCTOR NOW? Yes ____ No _____ (list all Dr.'s name/address/number)

_____

_____

Do you anticipate any loss of earnings, due to accident related injuries?

Yes _____ No _____