

Are you currently represented by an attorney for any other matter? Yes No If yes, please give the name of the attorney and describe the matter for which you are represented.

Have you ever been involved in a lawsuit? Yes No If yes, please explain the nature, date, county and state of the lawsuit: _____

Married: Yes No If yes, spouse's name: _____

Children (Names/Ages): _____

Have you served in the military? Yes No If yes, in what branch did you serve? _____

Have you ever been convicted of a felony? Yes No If yes, please state the charge, date, county and state of the charge: _____

Please list any social or recreational organizations/clubs in which you are a member: _____

Please list any sports or social activities in which you participate on a regular basis: _____

III. Bankruptcy

Have you ever filed for bankruptcy? Yes No
If yes, please give Date: _____ Place: _____

Do you anticipate the need to file bankruptcy in the foreseeable future? If yes, please explain:

IV. Client Employment Information

Were you employed at the time of the accident? Yes No
If no, please proceed to the next section (Medical Information).
If yes, please complete the following:

Employer: _____

Address: _____

Street City State Zip

Phone: _____ Job Title/Description: _____

Salary: \$ _____ hourly/weekly/monthly/yearly

Have you missed any time from work because of the injuries you suffered in the accident or do you anticipate missing time from work in the future? Yes No
If no, please proceed to the next section (Medical Information)
If yes, please complete the following:

Employment start date: _____ Date you were terminated, if applicable: _____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? Yes No
If you are still unable to work because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) \$ _____

Did you file a Federal Income Tax Return for each year during the five years preceding this accident? Yes No

Employment History

What other types of positions/jobs have you held in the past? _____

Previous employers, dates of employment, salary: _____

Were you working a second job at the time of the accident? Yes No

If no, please proceed to the next section (Medical Information).

If yes, please complete the following:

Second Employer: _____

Address: _____
Street City State Zip

Phone: _____ Job Title/Description: _____

Second job salary: \$ _____ hourly/weekly/monthly/yearly

Employment start date: _____ Date you were terminated, if applicable: _____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? Yes No

If you are still unable to work your second job because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) \$ _____

V. Medical Information

Injuries/Conditions (Current and Past)

Description of injuries: _____

Were you hospitalized? Yes No

If yes, how many days? _____

Have you had any significant medical problems in the past? Yes No If yes, please explain: _____

Please check which of the following complaints/symptoms you experienced *prior* to this accident and whether you treated with a physician for the complaints:

<i>Condition</i>	<i>Treated with Physician</i>		<i>Physician Name, City, State</i>
neck pain	Yes	No	_____
back pain	Yes	No	_____
jaw pain	Yes	No	_____
headaches	Yes	No	_____
shoulder pain	Yes	No	_____
hip pain	Yes	No	_____
arthritis	Yes	No	_____
fibromyalgia	Yes	No	_____

Have you previously been injured in an automobile accident, work-related accident, fall or any other type of accident? Yes No If yes, please provide the following information:

<i>Date of Accident</i>	<i>Type of Accident</i>	<i>City/State</i>	<i>Injuries</i>
_____	_____	_____	_____
_____	_____	_____	_____

Has a physician placed you at “maximum medical improvement? (MMI) for the injuries suffered in this accident? Yes No Unknown If yes, name of physician: _____
Any percentage of impairment, if known: _____%

Please list any restrictions which your physician has imposed because of your injuries (i.e. lifting, bending, etc): _____

Loss of Consortium: Yes No

Do you have photographs depicting your injuries? **Yes** **No**

Health insurance coverage

Primary insurance company: _____
Address: _____
Telephone: _____ Policy No.: _____
Secondary insurance company: _____
Address: _____
Telephone: _____ Policy No.: _____

Medicare Information:

Are you eligible for Medicare?: Yes No
Have bills been submitted to Medicare for payment?: Yes No

Has Medicare paid any bills?: Yes No; Amount Paid: \$ _____
Do you expect to be eligible for Medicare in the next 36 months? Yes No

Medicaid Information:

Are you eligible for Medicaid?: Yes No
Have bills been submitted to Medicaid for payment?: Yes No
Has Medicaid paid any bills?: Yes No; Amount Paid: \$ _____

Social Service Information:

Has any Social Service Agency provided support or paid any bills for you with regard to this incident?:
Yes No
If yes, please identify the agency: _____

Short and/or Long Term Disability Information:

Do you have a Short Term Disability policy in effect?: Yes No
Insurance Company: _____; Policy No.: _____
Have any benefits been paid?: Yes No; Amount Paid: \$ _____

Do you have a Long Term Disability policy in effect?: Yes No
Insurance Company: _____; Policy No.: _____
Have any benefits been paid?: Yes No; Amount Paid: \$ _____

Social Security Information:

Are you collecting Social Security Disability?: Yes No
Benefit Paid \$ _____, per month since _____.

Have you applied for Social Security Disability?: Yes No
Date of Application: _____; Denial received _____;
Who made the application for you?: _____.

Medical treatment (Current and Past)

Please list below the name, city and state of all medical providers who have treated or examined you relative to your injuries:

Ambulance: _____

Hospital – Emergency Room only: _____

Hospital – Admitted: _____

Primary treating physician: _____

Chiropractor: _____

Orthopedist: _____

Neurologist: _____

Neurosurgeon: _____

Physiatrist (Physical Medicine/Rehabilitation): _____

Physical Therapy Facilities: _____

MRI/Diagnostic Testing Centers: _____

Other: _____

Have you ever treated with a chiropractor *prior to* this accident ? Yes No If yes, please provide the date of treatment, and name and address of chiropractor:

Please provide the name, city and state of all physicians with whom you have consulted AND all hospitals where you have been treated, **other than for this accident, within the past ten (10) years:**

VI. Automobile Accident Information

Date of Accident: _____ Time: _____ AM/PM

How did the accident happen? _____

How did your injuries occur (i.e. did you strike the dashboard/steering wheel/windshield with any part of your body? were you thrown forward? did your seat snap backwards? were you thrown from the vehicle?): _____

Location of accident (street/intersection): _____

City of accident: _____ County: _____

Did the police respond to the scene? Yes No What agency? _____

Were any citations issued? Yes No If yes, who was cited? what charge? _____

Were you wearing a seatbelt? Yes No Was a seatbelt available? Yes No

Were you driver/passenger? Did you own the vehicle in which you were riding? Yes No
If no, provide the name of the vehicle owner: _____

Was the vehicle in which you were riding damaged? Yes No If yes, what is the amount of
damage? \$_____

Did you take a blood alcohol test? Yes No If yes, BAC level: _____

List the names/addresses of all persons riding in the vehicle with you: _____

Name/address of *driver* of the at-fault vehicle: _____

Name/address of *owner* of the at-fault vehicle (if different from driver): _____

Did the driver of the at-fault vehicle take a blood alcohol test? Yes No Unknown

Eyewitnesses to accident: _____

Other potential defendants: _____

Were any photographs taken at the scene? Yes No If yes, by whom? _____

Do you have photographs depicting the damage to your vehicle? Yes No

VII. Automobile Insurance Information

Have you been involved in any automobile accident prior to/subsequent to this accident?
Yes No If yes, please provide the date, city and state of the accident(s):

Prior to this accident, had you made any claims under any automobile insurance policy?
Yes No
If yes, please provide the reason for the claim (i.e. property damage, personal injury) and the date
the claim was made: _____

Client's automobile insurance coverage

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage:	PIP	Yes	No	Deductible: _____
	Medical Payments	Yes	No	Limits: _____
	UM/UIM	Yes	No	Limits: _____
				Stacking/Non-stacking

Please list below all occupants of your home (over 16 years old) on the date of the accident, their relationship to you and ownership of any vehicles:

<i>Name</i>	<i>Relationship</i>	<i>Vehicle Owned</i>	<i>Insurance Company</i>

Additional vehicles owned by you:

Your Umbrella Insurance:

Do you have Umbrella insurance coverage?: Yes No; Amount: \$ _____
Insurance Company: _____; Policy No.: _____

If you were a passenger in a vehicle, please provide the insurance information for the owner of the vehicle in which you were riding

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage:	PIP	Yes	No	Deductible: _____
	Medical Payments	Yes	No	Limits: _____
	UM/UIM	Yes	No	Limits: _____

Information concerning the driver of the at-fault vehicle

