

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 Is 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

Driver's name: _____

Insurance Company _____

