





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 Federal Income Tax Returns 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 the treatment causing this medical malpractice condition, 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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.: \_\_\_\_\_

**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? Yes/No Is yes, please provide the date of treatment, and name and address of chiropractor: \_\_\_\_\_

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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:**

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### **VI. Medical Malpractice Information**

Date of incident: \_\_\_\_\_ Time of incident: \_\_\_\_\_AM/PM

Location of incident: \_\_\_\_\_  
*City State County*

Facts of incident: \_\_\_\_\_

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Name and address of primary treating physician: \_\_\_\_\_

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### **Primary defendant information**

Name/Address of health care provider: \_\_\_\_\_

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Insurance carrier, if known: \_\_\_\_\_

Attorney, if known: \_\_\_\_\_

**VII. Additional Information/Comments**

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**VIII. Toxic Exposure History**

**1. Exposures generally.**

(a) Have you often been exposed to the following:

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|---|-----|----|-----------|
| Asbestos  | YES | NO | UNCERTAIN |
| Chemicals (strong)  | YES | NO | UNCERTAIN |
| Cleaning agents other than soap   | YES | NO | UNCERTAIN |
| Cosmetics, especially face makeup   | YES | NO | UNCERTAIN |
| Deodorizers   | YES | NO | UNCERTAIN |
| Dust, fumes, Sprays, gases, or small airborne fibers                                    | YES | NO | UNCERTAIN |
| Gas furnace   | YES | NO | UNCERTAIN |
| Gasoline  | YES | NO | UNCERTAIN |
| Herbicides or weed killers  | YES | NO | UNCERTAIN |
| Moth balls  | YES | NO | UNCERTAIN |
| Motor vehicle exhaust   | YES | NO | UNCERTAIN |
| Noise (loud)  | YES | NO | UNCERTAIN |
| Pesticides, including flea powders  | YES | NO | UNCERTAIN |
| Rotting plant materials or mold   | YES | NO | UNCERTAIN |
| Sewage  | YES | NO | UNCERTAIN |
| Solvents (such as paint, paint thinners, paint strippers, glue, adhesive removers, etc. | YES | NO | UNCERTAIN |
| Tobacco smoke   | YES | NO | UNCERTAIN |
| Vibration (strong or continuous)  | YES | NO | UNCERTAIN |
| Wood stove or fireplace   | YES | NO | UNCERTAIN |

(b) Describe any places other than home or work where you spend time and might possibly have been exposed to toxic substances.

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**2. Exposures at home.**

(a) If other people in your household have been repeatedly ill, describe the illnesses

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(b) If there is poor ventilation at home, describe it.

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(c) If you live near any industrial or toxic waste site that may be giving off fumes, gas, or dust, or may be contaminating ground water, describe it.

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(d) Describe any home remodeling you have done, especially involving concrete mixing, installing insulation, painting or staining, wood stripping, sanding, grinding, or polishing.

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(e) Describe any hobby projects you have, especially those involving model building, wood working, pottery making, silk screening, photographic developing, painting, stained glass, gardening.

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### 3. Exposures at work.

(a) List the materials or substances with which you usually work.

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(b) List all chemical agents with which you ever work.

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(c) Describe any regular industrial hygiene evaluation or surveillance used at your work site.

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(d) Describe any protective equipment or clothing such as masks, respirators, gowns, gloves, etc. employees are sometimes required to use.

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(e) Describe any protective equipment or clothing such as masks, respirators, gowns, gloves, etc. you sometimes use.

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(f) Describe any safety training you received to reduce your exposure to toxic substances or harmful agents.

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(g) Describe any exposures to toxic substances or harmful agents you believe you may have received.

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(h) If other employees at your work site have been repeatedly ill, describe the illnesses

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(i) If there is poor ventilation at your work site, describe it.

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(j) If you work near any industrial or toxic waste site that may be giving off fumes, gas, or dust, or may be contaminating ground water, describe it.

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