DALE APPELL
PERSONAL INJURY LAW

CLIENT INTAKE AND CASE INFORMATION QUESTIONNAIRE

(MOTOR VEHICLE ACCIDENT)

PARTY

DATE: _____

LEGAL NAME: _____ SEX: _____ DOB: _____ SSN: _____
NICKNAME: _____

ADDRESS: _____ LESS THAN 2 YEARS, PRIOR ADDRESS:_____

_____ _____

PHONE: _____(HOME) _____ (FAX)

_____ (OFFICE) _____ (E-MAIL)

_____ (CELL/OTHER)

MARITAL STATUS: MARRIED DIVORCED SINGLE SEPARATED DOMESTIC PARTNER WIDOW/ER
(CIRCLE ONE)
SPOUSE'S NAME (IF APPLICABLE): _____

YOUR FORMER NAME(S): _____ _____

DEPENDENTS/AGES: _____ _____

_____ _____

PRIOR ACCIDENTS: _____ _____

_____ _____

EMERGENCY CONTACT NAME (SOMEONE NOT IN YOUR CURRENT HOUSEHOLD):
NAME _____ RELATIONSHIP: _____
TELEPHONE NUMBER: _____
ADDRESS: _____

_____

DO YOU HAVE ANY PLANS TO FILE FOR BANKRUPTCY IN THE NEAR FUTURE? YES NO

DO YOU LIVE WITH ANY PERSON WHO IS INSURED UNDER A DIFFERENT POLICY THAN YOU ARE? YES NO

HAVE YOU EVER BEEN ARRESTED? YES NO (IF YES, PLEASE EXPLAIN) _____

_____

CASE

DATE OF INCIDENT: _____

PROVIDE A BRIEF DESCRIPTION OF WHAT OCCURRED: _____

_____

_____

LOCATION OF CRASH (NEAREST STREET/INTERSECTION): _____
CITY: _____ COUNTY: _____ TIME: _____

WHERE WERE YOU COMING FROM? _____ GOING TO?: _____

NUMBER OF VEHICLES INVOLVED: _____ WERE YOU WEARING YOUR SEATBELT? YES NO

POSITION IN VEHICLE: DRIVER PASSENGER: WHICH SEAT? _____

OTHER PASSENGERS: _____ _____
_____ _____

WEATHER CONDITIONS: CLEAR DRY SUNNY RAINY WET FOGGY OVERCAST/CLOUDY
(CIRCLE ALL THAT APPLY)

WAS ANYONE CHARGED IN THE CRASH? YES NO IF YES, WHOM?: _____
TYPE OF OFFENSE: _____

NAME OF DEFENDANT DRIVER: _____

WERE THERE ANY WITNESSES TO THE CRASH? YES NO IF YES, WHOM?: _____
_____

WHAT INFORMATION WOULD THESE WITNESSES HAVE?

_____

_____

CONTACT INFO FOR WITNESSES: _____
_____

THE NAME OF THE AMBULANCE CO IF APPLICABLE?_____

HAVE YOU PROVIDED A RECORDED STATEMENT TO ANY INSURANCE COMPANY? YES NO
IF YES, TO WHOM?: _____

DO YOU HAVE HEALTH INSURANCE/MEDICARE/MEDICAID? YES NO
NAME OF CARRIER: _____ (WE WILL NEED A COPY OF YOUR CARD)

WHAT IS YOUR DRIVING HISTORY IN THE LAST SEVEN YEARS? _____

_____

DO YOU HAVE ANY RESTRICTIONS ON YOUR DRIVER'S LICENSE? _____

PROPERTY DAMAGE

DESCRIBE THE DAMAGE TO YOUR VEHICLE: _____
DOLLAR AMOUNT OF DAMAGE: _____

YEAR, MAKE, MODEL OF YOUR VEHICLE: _____
OWNER'S NAME: _____

HOW WAS THE VEHICLE REMOVED FROM THE SCENE? DRIVEN AWAY TOWED

WERE THERE PHOTOS TAKEN OF THE DAMAGE? YES NO IF YES, BY WHOM? _____

DESCRIBE THE DAMAGE TO THE OTHER VEHICLE: _____
ESTIMATED DOLLAR AMOUNT OF DAMAGE: _____

YEAR, MAKE, MODEL OF THIS VEHICLE: _____

DESCRIBE THE DAMAGE TO ADDITIONAL VEHICLE: _____
ESTIMATED DOLLAR AMOUNT OF DAMAGE: _____

YEAR, MAKE, MODEL OF THIS VEHICLE: _____

VALUE

HAVE YOU INCURRED ANY OUT-OF-POCKET EXPENSES AS A RESULT OF THIS CRASH? YES NO
IF YES, PLEASE DESCRIBE TYPE AND AMOUNT: _____ $_____
(PRESCRIPTIONS, CO-PAYS, DEDUCTIBLES) _____ $_____
_____ $_____

POLICE

WHICH LAW ENFORCEMENT AGENCY RESPONDED TO THE CRASH SCENE? _____
DO YOU HAVE A COPY OF THE REPORT? REPORT NUMBER: _____

EMPLOYMENT

CURRENT EMPLOYER: _____ POSITION: _____
ADDRESS: _____
_____

NAME OF SUPERVISOR: _____

RATE OF PAY: _____ PER HOUR PER WEEK PER MONTH PER YEAR

HAVE YOU LOST WAGES DUE TO YOUR INJURIES IN THIS CRASH? YES NO
IF YES, HOW MUCH?: _____

INSURANCE

NAME OF YOUR INSURANCE CARRIER: _____
ADDRESS: _____
_____
_____

CONTACT NUMBER: _____
ADJUSTER NAME: _____
POLICY NUMBER: _____
CLAIM NUMBER: _____
LIMITS OF COVERAGE: PIP: $_____
MED PAY: $_____
UNINSURED MOTORIST (UM): $_____

NAME OF OTHER PARTY'S CARRIER: _____
ADDRESS: _____
_____
_____

CONTACT NUMBER: _____
ADJUSTER NAME: _____
POLICY NUMBER: _____
CLAIM NUMBER: _____
LIMITS OF COVERAGE: BODILY INJURY (BI): $_____
GENERAL LIAB (GL): $_____

NAME OF ADDITIONAL PARTY'S CARRIER: _____
ADDRESS: _____
_____
_____

CONTACT NUMBER: _____
ADJUSTER NAME: _____
POLICY NUMBER: _____
CLAIM NUMBER: _____
LIMITS OF COVERAGE: BODILY INJURY (BI): $_____
GENERAL LIAB (GL): $_____

NAME OF ADDITIONAL PARTY'S CARRIER: _____
ADDRESS: _____
_____
_____

CONTACT NUMBER: _____
ADJUSTER NAME: _____
POLICY NUMBER: _____
CLAIM NUMBER: _____
LIMITS OF COVERAGE: BODILY INJURY (BI): $_____
GENERAL LIAB (GL): $_____

MEDICAL

PROVIDE THE NAMES AND ADDRESSES OF ALL MEDICAL PROVIDERS YOU HAVE SEEN FOR YOUR INJURIES:

NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:	NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:
NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:	NAME: ADDRESS: TELEPHONE: TYPE OF TREATMENT RECEIVED:

GENERAL HEALTH

PRIOR TO THIS CRASH, WHAT WAS THE STATE OF YOUR HEALTH (HIGH BLOOD PRESSURE, DIABETES, ETC)?

_____

_____

NAMES OF TREATING PHYSICIANS: _____

_____

_____

WERE YOU TAKING ANY MEDICATIONS REGULARLY PRIOR TO THIS CRASH? YES NO

IF YES, PLEASE NAME THEM: _____

_____

HAVE YOU HAD ANY PRIOR INJURIES? YES NO IF YES, PLEASE DESCRIBE: _____

_____

_____

_____

_____

INJURIES

PLEASE DESCRIBE ANY INJURIES TO ANY OF THE FOLLOWING PARTS OF YOUR BODY AND HOW OFTEN YOU FEEL PAIN. DESCRIBE WHAT THE PAIN FEELS LIKE. (IF YOU HAVE NO INJURY, PLEASE WRITE NONE)

HEAD: _____

JAW/MOUTH: _____

NECK: _____

SHOULDERS: R L BOTH _____

UPPER BACK: _____

ARMS: R L BOTH _____

HANDS: R L BOTH _____

CHEST: _____

TORSO: _____

ANY PROBLEMS WITH INTERNAL ORGANS?: _____

MID BACK: _____

HIPS: R L BOTH _____

LOW BACK: _____

LEGS: R L BOTH _____

FEET: R L BOTH _____

ANY OTHER SYMPTOMS OR PROBLEMS: _____

_____

WERE YOU HOSPITALIZED? YES NO HAVE YOU HAD AN MRI? YES NO

HAVE YOU TAKEN PHOTOS OF YOUR INJURIES? YES NO DO YOU HAVE ANY SCARRING? YES NO

HAVE YOU PURCHASED OR WERE YOU PROVIDED ANY MEDICAL SUPPLIES? YES NO IF, YES: _____

_____

HAVE YOU HAD ANY INJURIES SINCE THIS CRASH? YES NO IF YES, PLEASE DESCRIBE: _____

_____

HOW HAS THIS CRASH AFFECTED YOUR PERSONAL LIFE [HOBBIES, RELATIONSHIPS, ETC.]? _____

_____

_____

_____