DALE APPELL
PERSONAL INJURY LAW

CLIENT INTAKE AND CASE INFORMATION QUESTIONNAIRE

(MEDICAL MALPRACTICE)

PARTY

DATE: ___________

LEGAL NAME: ____________________________ SEX: ______ DOB: _____ SSN: ___________
NICKNAME: ____________________________

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): RELATIONSHIP: ___________
TELEPHONE NUMBER: ______________________
ADDRESS: ______________________
____

DO YOU HAVE ANY PLANS TO FILE FOR BANKRUPTCY IN THE NEAR FUTURE? 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 INCIDENT: ____________________

CITY: ____________________ COUNTY: ____________________ TIME: ____________________

STATE WHO YOU FEEL IS/ARE THE RESPONSIBLE PARTY/IES FOR YOUR INJURY?

____

____

DID YOU SIGN ANY WAIVER OR RELEASE? YES NO

DO YOU HAVE A COPY? YES NO

WAS AN INCIDENT REPORT TAKEN? YES NO IF YES, BY WHOM?: ____________________

DO YOU HAVE A COPY? YES NO

WERE THERE ANY WITNESSES TO THE INCIDENT? YES NO IF YES, WHOM?: ____________________

____

WHAT INFORMATION WOULD THESE WITNESSES HAVE?

____

____

CONTACT INFO FOR WITNESSES: ____________________

____

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)

INSURANCE

NAME OF DEFENDANT'S CARRIER: ____________________

ADDRESS: ____________________

____

CONTACT NUMBER: ____________________

ADJUSTER NAME: ____________________

CLAIM NUMBER: ____________________

LIMITS OF COVERAGE: GENERAL LIAB (GL): $____________________

MED PAY: $____________________

VALUE

HAVE YOU INCURRED ANY OUT-OF-POCKET EXPENSES AS A RESULT OF THIS INCIDENT? YES NO

IF YES, PLEASE DESCRIBE TYPE AND AMOUNT: ____________________ $__________________

(PRESCRIPTIONS, CO-PAYS, DEDUCTIBLES) ____________________ $__________________

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 INCIDENT? YES NO

IF YES, HOW MUCH?: _________________________________

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 INCIDENT, 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 INCIDENT? 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 INCIDENT? YES NO IF YES, PLEASE DESCRIBE: ______________

____

HOW HAS THIS INCIDENTAFFECTED YOUR PERSONAL LIFE [HOBBIES, RELATIONSHIPS, ETC.]? ______________

____

____

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