CLIENT INTAKE FORM—PERSONAL INJURY—MOTOR VEHICLE COLLISION

(Instructions: Please complete this and mail or fax it to us as soon as possible. Any delay in doing so will only delay our evaluation of your case.)

CLIENT'S INFORMATION

Name: _____ Date of Birth: _____ SSN: _____-____-_____
Street Address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell phone: _____ E-mail: _____

INSURANCE

Who is your insurance company?
Name of company: _____ Policy #: _____
Address: _____
Phone: _____
Have you reported the accident to your insurance company? _____Yes _____No
If yes, have you been contacted by one of their adjusters? _____Yes _____No
If yes, please give his or her information:
Name: _____
Address: _____
Phone: _____

Please provide the names of the other driver(s) involved:

Don't know—hit and run _____ (check if applicable)

Name: _____
Address: _____
Name of insurance company: _____

Name: _____
Address: _____
Name of insurance company: _____

Name: _____
Address: _____
Name of insurance company: _____

(If more than three drivers were involved, please use the back of this page. ___ Check if you are using the back.)

THE ACCIDENT

Date of Accident: _____
Place of Accident: _____
(physical address or location; e.g. intersection or mile marker)
City _____ County _____
Time of Day: _____ am/pm

Please describe what happened: _____
_____
_____
_____
_____
_____

Please note: No attorney-client relationship is created by your completion and submission or our receipt of this form.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Were you issued a citation? _____Yes _____No
If, yes, what citation? _____
If yes, have you been to court? _____Yes _____No
If you have gone to court, please describe the disposition:_____
_____

Were any of the other drivers issued citations? _____Yes _____No _____Don't know
If yes, and if you know, please list the citations

Driver	Citation
_____	_____
_____	_____
_____	_____
_____	_____

Have any of the other drivers' insurance companies contacted you? _____Yes _____No
If yes, provide the following:
Name of company: _____ Adjuster's Name: _____
Address: _____
Phone: _____
Did you give a statement? _____Yes _____No

Name of company: _____ Adjuster's Name: _____
Address: _____
Phone: _____
Did you give a statement? _____Yes _____No

If you received any correspondence from any of these companies, please bring it in so we can make copies for our file.

INJURIES
Please use the attached Medical Treatment Questionnaire to describe your injuries

WORK STATUS
Were you working at the time of your accident? _____Yes _____No
If yes, please provide the following:
Your occupation or job title: _____
Compensation $_____ (hourly/weekly/monthly/annually)
Name of Employer: _____
Your supervisor's name: _____
Address: _____

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Phone: _____
How long have you been employed there? _____(years/months/weeks)

Did you miss any work as a result of your injuries? _____Yes _____No
We will attempt to obtain documentation of the time missed from your employer, but it may be necessary for you to obtain it for us. We will let you know.

If yes, have you returned to work? _____Yes _____No If yes, when: ____/____/_____

If you missed work, have you received any disability income? _____Yes _____No
If yes, provide the following:
Name of company: _____ Policy #: _____
Address: _____
Phone: _____

Were you on the job at the time of your accident? _____Yes _____No
If yes, have you filed a workers compensation claim? _____Yes _____No
If yes, please provide the following:
Name your employer's workers compensation insurer: _____
Policy #: _____
Address: _____
Phone: _____

OTHER ACCIDENTS
Please provide the following information for any other accidents you have had *before* or *since* the accident you are asking us to represent you for. If you have had more than three other accidents, please use additional copies of page 4. Begin with the most recent and list them in reverse chronological order.

Date of Accident: _____
Place of Accident: _____
(physical address or location; e.g. intersection or mile marker)
City _____ State _____
Time of Day: _____ am/pm Were you driving _____ or a passenger _____?

What vehicle were you driving or in? Make _____ Model _____ Year _____ Color _____

Please describe what happened (including any injuries you suffered):_____
_____
_____
_____
_____
_____
_____

Were you represented my an attorney? _____Yes _____No
If yes, give Name _____ Address_____
Were you issued a citation? _____Yes _____No
Was an accident report issued? _____Yes _____No _____Don't remember or don't know

Did you make an insurance claim? _____Yes _____No
Name of insurance company _____

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OTHER ACCIDENTS (continued)

Date of Accident: _____
Place of Accident: _____
(physical address or location; e.g. intersection or mile marker)
City _____ State _____
Time of Day: _____ am/pm Were you driving _____ or a passenger _____?

What vehicle were you driving or in? Make _____ Model _____ Year _____ Color _____

Please describe what happened (including any injuries you suffered):_____
_____
_____
_____
_____
_____
_____
_____

Were you represented my an attorney? _____Yes _____No
If yes, give Name _____ Address_____

Were you issued a citation? _____Yes _____No
Was an accident report issued? _____Yes _____No _____Don't remember or don't know

Did you make an insurance claim? _____Yes _____No
Name of insurance company _____

Date of Accident: _____
Place of Accident: _____
(physical address or location; e.g. intersection or mile marker)
City _____ State _____
Time of Day: _____ am/pm Were you driving _____ or a passenger _____?

What vehicle were you driving or in? Make _____ Model _____ Year _____ Color _____

Please describe what happened (including any injuries you suffered):_____
_____
_____
_____
_____
_____
_____

Were you represented my an attorney? _____Yes _____No
If yes, give Name _____ Address_____

Were you issued a citation? _____Yes _____No
Was an accident report issued? _____Yes _____No _____Don't remember or don't know

Did you make an insurance claim? _____Yes _____No
Name of insurance company _____

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OTHER PERTINENT INFORMATION

Please provide any other information (other than that requested in the Medical Treatment Questionnaire) that is pertinent to your case: _____

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