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PERSONAL INJURY ACTION INTERVIEW FORM

DATE:_____ *STATUTE RUNS:_____

REFERRAL SOURCE:_____ BY:_____

CLIENT'S PERSONAL INFORMATION

NAME:_____

ADDRESS:_____

TELEPHONE: (H)_____(W) _____(C) _____

EMAIL ADDRESS: _____

COUNTY OF RESIDENCE:_____

Gender: Male____ Female____

SSN: _____ DATE OF BIRTH:_____ AGE:___

DRIVER'S LICENSE: No:_____ State:___ Expiration:_____

Driving Record:_____

MARITAL STATUS:_____ SPOUSE'S NAME:_____ Length____

CHILDREN: [Names and ages]_____
_____

CLIENT'S EMPLOYMENT

Occupation:_____ Employer:_____ How long:_____
Work Schedule:_____
Hourly Wage:_____ Overtime [yes][no]

EDUCATION LEVEL:_____

CLIENT'S MEDICAL INSURANCE COVERAGE

Do you have medical insurance? If so, please provide a copy of the card(s). □Yes □ No

Are you a Medicaid or Medicare recipient? If so, please provide a copy of the card(s).
□Yes □ No

Did Medicaid or Medicare pay for any treatment as a result of this accident? □Yes □ No

Have you received any subrogation letters? ? If so, please provide a copy. □ Yes □ No

INFORMATION ABOUT THE INCIDENT

Date/Time of Incident:_____

Location of Incident:_____

Investigated by:_____

Did you speak with the officer at the scene? If so, what was the nature of your conversation? □ Yes □ No _____
_____

Did you speak with anyone at the scene? If so, who and what was the nature of your conversation(s)? □ Yes □ No _____
_____

Client's role: [Driver, Passenger, Owner, etc.]:_____

_____

_____

Other persons in the car:_____

Description of Incident:_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any extenuating or unordinary issues regarding the at-fault driver or the accident itself which you feel needs to be addressed? If so, list them? □ Yes □ No

_____

_____

Type of Vehicles involved:_____

_____

Person/Parties responsible for incident:_____

_____

Charges filed against at-fault driver:_____ Court Date:_____

Did you receive any citations as a result of this accident? If so, list them? □ Yes □ No
_____ Court Date:_____

Photographs or videotape of vehicle or accident site? If so, provide copies. □ Yes □ No

Were you wearing your seatbelt? □ Yes □ No

Were your passengers wearing their seatbelts (if applicable)? □ Yes □ No

If this was a motorcycle accident, were you wearing a helmet? □ Yes □ No

If this was a motorcycle accident, was your passenger wearing a helmet (if applicable)? □ Yes □ No

Was your vehicle drivable? □ Yes □ No

Were the other vehicle(s) drivable? □ Yes □ No

WITNESSES

[Indicate at right [Y] [N] if statement made to insurance adjuster/officer]

	Names	Phone Numbers	Addresses	
1.	_____	(h)_____	_____	[Y][N]
		(w)_____	_____	
2.	_____	(h)_____	_____	[Y][N]
		(w)_____	_____	

3. _____ (h)_____ _____[Y][N]

(w)_____ _____

4. _____ (h)_____ _____[Y][N]

(w)_____ _____

5. _____ (h)_____ _____[Y][N]

(w)_____ _____

CLIENT'S VEHICLE INSURANCE COVERAGE

Insurance Company:_____
Policy Number: _____
Claim Number and Contact Person: _____
Did you provide a statement to the insurance company? □ Yes □ No
Liability (List Amounts):_____
UM (List Amounts);_____
UIM (List Amounts):_____
PIP/Medpay (List Amounts):_____
Other (List Amounts):_____
How many vehicles do you have in your household? _____
Do you have the automobile insurance declarations page of the vehicle you were in at the time of the accident? □Yes □ No If so, please provide a copy.

AT-FAULT VEHICLE OWNER'S VEHICLE INSURANCE INFORMATION

Insurance Company:_____
Policy Number: _____
Claim Number and Contact Person: _____
Did you provide a statement to the insurance company? □ Yes □ No
Liability (List Amounts):_____
PLUP (List Amounts):_____

AT-FAULT DRIVER'S VEHICLE INSURANCE INFORMATION IF HE/SHE IS NOT THE OWNER OR DOES NOT RESIDE WITH THE OWNER OF THE AT-FAULT VEHICLE

Insurance Company:_____
Policy Number: _____
Claim Number and Contact Person: _____
Did you provide a statement to the insurance company? □ Yes □ No
Excess Liability (List Amounts):_____
PLUP (List Amounts):_____

INFORMATION REGARDING INJURIES/DAMAGES

Describe Injuries (please be sure to list specific body parts that are affected, i.e., right leg, left arm, lower back, neck, etc.): _____

_____

_____

_____

_____

Any pre-existing injuries aggravated by this accident? If so, please explain: □ Yes □ No

_____

_____

_____

Were you ambulated from the scene? □ Yes □ No

If so, what facility transported you? _____

What hospital did you go to? _____

Did you receive x-rays, CT-scans, or MRI's at the ER? □ Yes □ No

Where were you treated after the ER? □ Yes □ No If so, please list all physicians.

Physicians:	Name	Specialty	Phone	Address
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Hospitals:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Pharmacies:	_____	_____	_____	_____
	_____	_____	_____	_____

Did you receive x-rays, CT-scans, or MRI's during the subsequent treatment (after the ER) with your physicians listed above? □ Yes □ No

Do you have prescriptions which you need to be reimbursed for? If so, please provide copies. □ Yes □ No

Provide any and all mileage to and from your doctor's office, physical therapy, drug store, etc._____

_____

Do you have photographs of scarring or injuries? If so, provide copies. □ Yes □ No

Is there any lapse in treatment? If, so why? _____

_____

Prior Injuries or illnesses: [Give dates and outcomes]

_____

_____

_____

Prior suits or claims: [Give dates, locations, and outcome of suit or claim]

_____

_____

_____

_____

Offers of settlement for this accident:

_____

_____

I certify that the foregoing information is true and correct to the best of my knowledge, information, and belief. I understand that no promises have been made to me regarding the outcome of, or any result in, this case. I further understand that whether or not I am able to collect any compensation depends, in part, upon the extent that the other parties and their insurance carriers may be willing to cooperate and upon whether a court may be willing to award such compensation. I also understand any embellishment or misrepresentation of my injuries or the expenses and costs associated therewith may have a direct adverse effect on my ability to receive adequate compensation therefore, and may increase my legal fees and costs as a result.

Signed:_____ Date: _____