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PREMISES CONFIDENTIAL CLIENT INFORMATION FORM

This questionnaire is a confidential questionnaire for the use of our office only in preparing your claim for personal injuries. The information you furnish us will not be released and will be held strictly confidential. When your claim has been concluded, we will return this questionnaire to you if you wish. Please answer every question fully and accurately, because as your attorneys, we must know all about you and your case. One surprise, because of an incorrect or incomplete answer could cause you to lose your case.

CASE INFORMATION

DATE OF ACCIDENT: _____

PLAINTIFF INFORMATION

1. FULL NAME: _____
   First Middle Last

2. BIRTHPLACE: _____

3. DATE OF BIRTH: _____

4. SOCIAL SECURITY NUMBER: _____

5. ADDRESS: _____

6. PHONE NUMBER: HOME: _____ WORK: _____

   CELL: _____

7. E-MAIL ADDRESS: _____

8. MARITAL STATUS: _____

9. SPOUSE'S NAME: _____

10. IF DIVORCED, DATE AND PLACE: _____

11. IF SPOUSE DECEASED, DATE OF DEATH: _____

12. NAMES, AGES AND ADDRESS OF ALL THOSE (INCLUDING CHILDREN) WHO ARE DEPENDENT UPON YOU FOR SUPPORT, AND YOUR RELATIONSHIP TO EACH:

NAME	ADDRESS	AGE	RELATIONSHIP

_____

_____

_____

13. NAME, ADDRESS, E-MAIL AND PHONE NUMBER OF FAMILY MEMBER OR FRIEND WHO WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU FOR ANY REASON:

_____

_____

_____

14. PLEASE PROVIDE ALL ADDRESSES FOR THE LAST TEN YEARS, THE DATES OF THE RESIDENCE, THE PERSONS RESIDING AT THE ADDRESSES WITH PLAINTIFF AND THE RELATION, IF ANY, TO THE PLAINTIFF.

_____

_____

_____

CLIENT'S INSURANCE

NAME, ADDRESS AND POLICY NUMBER OF HEALTH INSURANCE COMPANY:

_____

_____

ADDITIONAL INSURANCE

1. ARE YOU ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

2. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO

IF SO, PLEASE LIST MEDICARE AND/OR MEDICAID ID NUMBER.

_____

3. PLEASE CHECK IF ANY OF YOUR MEDICAL BILLS HAVE BEEN SUBMITTED TO ANY OF THE FOLLOWING:

☐ MEDICARE/MEDICAID
☐ HEALTH INSURANCE COMPANY
☐ _____ (Other - Please complete name of company)

IF YOUR MEDICAL BILLS HAVE BEEN SUBMITTED TO MEDICARE, MEDICAID AND/OR YOUR PRIVATE HEALTH INSURANCE COMPANY, THERE MAY BE A LIEN ON THE MONEY PAID BY YOUR INSURER.

PLEASE PROVIDE A COPY OF YOUR MEDICARE, MEDICAID AND/OR HEALTH INSURANCE CARD.

OTHER INFORMATION

1. DO YOU BELONG TO ANY SOCIAL NETWORKING SITES (e.g., Facebook, Twitter, MySpace, LinkedIn, Bebo, hi5, Orkut, PerfSpot, Yahoo!360, Zorpia, Netlog, Snapchat, Instagram, etc.)? ☐ YES ☐ NO

2. IF SO, LIST EACH SITE TO WHICH YOU BELONG AND YOUR USERNAME OR HANDLE FOR EACH ACCOUNT:

SITE: _____ USERNAME/HANDLE: _____

SITE: _____ USERNAME/HANDLE: _____

SITE: _____ USERNAME/HANDLE: _____

(IF YOU NEED MORE SPACE, YOU MAY ATTACH EXTRA PAGES)

WARNING! ANY INFORMATION, PICTURES, OR VIDEOS POSTED ON SOCIAL NETWORKING SITES MAY AFFECT YOUR CLAIM. EVEN IF YOU HAVE LIMITED WHO MAY ACCESS YOUR ACCOUNT, ALL INFORMATION MAY BE SHARED IN LITIGATION THROUGH THE DISCOVERY PROCESS.

IN NO EVENT SHOULD YOU DELETE ANY INFORMATION FROM YOUR SOCIAL MEDIA SITES, NOR SHOULD YOU TAKE DOWN YOUR PROFILES, AS THAT MAY BE HELD TO BE A VIOLATION OF YOUR DUTY TO PRESERVE ALL EVIDENCE RELEVANT TO YOUR CLAIM.

3. IF YOU OR ANY OTHER PARTY OR WITNESSES KNOWN TO YOU CONSUMED ANY ALCOHOLIC BEVERAGES, DRUGS OR MEDICATION, INCLUDING PRESCRIPTION MEDICATION WITHIN TWELVE (12) HOURS BEFORE THE ACCIDENT, STATE THE NAME OF THE PERSON;

WHAT WAS CONSUMED; THE QUANITTY; WHERE CONSUMED AND THE NAMES AND ADDRESSES OF ALL PERSONS PRESENT.

_____

_____

_____

FACTS OF THE ACCIDENT

1. DATE: _____ DAY: _____ TIME: _____

2. EXACT LOCATION OF ACCIDENT:

_____

_____

3. DAYLIGHT, DUSK OR DARK? _____

4. WEATHER: _____

5. DESCRIBE WHAT HAPPENED:

_____

_____

_____

FACTS CONCERNING THE OTHER PARTY

1. NAME OF OTHER PARTY: _____

2. ADDRESS: _____

3. WHO IS THE OWNER OF THE PROPERTY WHERE THE ACCIDENT OCCURRED: _____

4. OTHER PARTY'S INSURANCE COMPANY: _____

5. STATE THE NAMES OF ANY TENANTS OCCUPYING THE PROPERTY WHERE THE ACCIDENT OCCURRED:

_____

_____

6. STATE THE NAME OF ANY PROPERTY MANAGEMENT COMPANY WITH RESPONSIBILITY FOR THE UPKEEP OF THE PROPERTY WHERE THE ACCIDENT OCCURRED:

_____

_____

7. GIVE YOUR OBSERVATIONS ABOUT THE PARTY AS A PERSON:

_____

_____

WITNESSES

LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL WITNESSES TO THE ACCIDENT. (PERSON WHO SAW OR MAY HAVE SEEN THE ACCIDENT).

1. NAME: _____

   ADDRESS: _____

   PHONE: _____ AGE: _____ JOB: _____

   WHAT DOES HE/SHE KNOW: _____

2. NAME: _____

   ADDRESS: _____

   PHONE: _____ AGE: _____ JOB: _____

   WHAT DOES HE/SHE KNOW: _____

PLEASE ALSO LIST ANY PEOPLE WHO MAY HAVE INFORMATION ABOUT THE ACCIDENT OR THE CONDITION THAT CAUSED THE ACCIDENT.

1. NAME: _____

   ADDRESS: _____

   PHONE: _____ AGE: _____ JOB: _____

   WHAT DOES HE/SHE KNOW: _____

2. NAME: _____

   ADDRESS: _____

   PHONE: _____ AGE: _____ JOB: _____

   WHAT DOES HE/SHE KNOW: _____

LIST OF NAMES

List ten names and addresses of people who can best explain how the injuries from the accident have affected your life including changes in your activities since the accident. These people may include family, friends, neighbors, co-workers, etc. This list of names should also include people who performed hobbies and activities with you that you can no longer perform due to the injuries sustained in the accident.

1. NAME: _____

   ADDRESS: _____

2. NAME: _____

   ADDRESS: _____

3. NAME: _____

   ADDRESS: _____

4. NAME: _____

   ADDRESS: _____

5. NAME: _____

   ADDRESS: _____

6. NAME: _____

   ADDRESS: _____

7. NAME: _____

   ADDRESS: _____

8. NAME: _____

   ADDRESS: _____

9. NAME: _____

   ADDRESS: _____

10. NAME: _____

    ADDRESS: _____

PHOTOGRAPHS

DO YOU HAVE PHOTOGRAPHS OF THE SITE OF YOUR ACCIDENT OR YOUR DAMAGES? _☐_ YES _☐_ NO

IF YES, PLEASE SEND THE PHOTOGRAPHS TO OUR OFFICE.

IF NO, PLEASE MAKE SURE YOU OBTAIN PHOTOGRAPHS IMMEDIATELY.

STATEMENTS MADE

1. HAVE YOU TOLD ANY POLICE OFFICER, INVESTIGATOR, INSURANCE ADJUSTER OR ANY OTHER PERSON ABOUT THE ACCIDENT?
_☐_ YES _☐_ NO

2. HAVE YOU GIVEN ANY WRITTEN STATEMENT TO ANY PERSON ABOUT THE ACCIDENT? _☐_ YES _☐_ NO

IF SO, ANSWER THE FOLLOWING:

A. NAME OF THE PERSON TO WHOM THE STATEMENT WAS GIVEN:
_____

B. DATE GIVEN: _____

C. PERSONS PRESENT AT THE TIME:
_____

D. IF WRITTEN DO YOU HAVE A COPY? _☐_ YES _☐_ NO

E. DID YOU SIGN THE STATEMENT? _☐_ YES _☐_ NO

3. PLEASE GIVE US ANY STATEMENT YOU KNOW THE OTHER PARTY MADE ABOUT THE ACCIDENT, OR THAT YOU UNDERSTAND HE/SHE MAY HAVE MADE:
_____

_____

_____

4. WHEN AND WHERE MADE: _____

5. NAME AND ADDRESS OF PERSON WHO HEARD IT:

_____

_____

DAMAGES FROM THE ACCIDENT

THE AMOUNT OF RECOVERY MADE IN THIS CASE WILL BE AFFECTED BY THE DAMAGES OR EXPENSES INCURRED AS A RESULT OF YOUR ACCIDENT. IT IS IMPORTANT THAT YOU FULLY LIST ALL INFORMATION REGARDING YOUR INJURIES AND YOUR EXPENSES AS A RESULT OF THIS ACCIDENT.

1. STATE IN FULL DETAIL, ALL INJURIES YOU RECEIVED AS A RESULT OF THE ACCIDENT:

_____

_____

_____

_____

_____

2. STATE YOUR PRESENT PHYSICAL CONDITION - SCARS, DEFORMITIES, HEADACHES, PAINS, ETC., DUE TO INJURIES SUSTAINED IN THIS ACCIDENT:

_____

_____

_____

_____

_____

3. HAVE YOU MISSED ANY TIME FROM WORK AS A RESULT OF YOUR INJURY? IF SO, LIST THE INCLUSIVE DATES YOU WERE UNABLE TO WORK:

FROM: _____ TO: _____

FROM: _____ TO: _____

4. DID YOU LOSE WAGES FOR THE PERIODS OF TIME MISSED FROM WORK DUE TO THIS ACCIDENT? _☐_ YES _☐_ NO

IF SO, STATE THE TOTAL WAGES LOST TO DATE AND THE DATES.

_____

5. LIST ALL HOSPITALS IN WHICH YOU WERE EXAMINED OR TREATED, OR TO WHICH YOU WERE ADMITTED AS A PATIENT AS A RESULT OF THE INJURIES SUSTAINED IN THE ACCIDENT, THE DATES AND THE TOTAL COSTS:

A. HOSPITAL: _____

ADDRESS: _____

DATE OF EMERGENCY ROOM TREATMENT: _____

DATES OF ADDMISSION: FROM: _____ To: _____

B. HOSPITAL: _____

ADDRESS: _____

DATE OF EMERGENCY ROOM TREATMENT: _____

DATES OF ADDMISSION: FROM: _____ To: _____

6. LIST THE FULL NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PHYSICIAN OR SURGEON WHO HAS EXAMINED OR TREATED YOU FOR YOUR INJURIES AS A RESULT OF THE ACCIDENT:

A. DOCTOR'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

TYPE OF TREATMENT: _____

B. DOCTOR'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

TYPE OF TREATMENT: _____

7. IF YOU WERE GIVEN PHYSICAL THERAPY OR OTHER THERAPY NOT DIRECTLY GIVEN BY A PHYSICIAN, LIST THE FULL NAME, ADDRESS AND TELEPHONE NUMBER OF EACH MEDICAL PROVIDER AND STATE WHAT PHYSICIAN ORDERED EACH PARTICULAR THERAPY:

A. THERAPY PROVIDER: _____

ADDRESS: _____

PHONE NUMBER: _____

PHYSICIAN WHO ORDERED THERAPY: _____

APPROXIMATE DATES OF THERAPY: _____

B. THERAPY PROVIDER: _____

ADDRESS: _____

PHONE NUMBER: _____

PHYSICIAN WHO ORDERED THERAPY: _____

APPROXIMATE DATES OF THERAPY: _____

8. LIST HERE ALL OF YOUR USUAL ACTIVITIES WHICH YOU HAVE NOT BEEN ABLE TO PERFORM, OR CAN ONLY PERFORM WITH DIFFICULTY, SINCE THE ACCIDENT, SUCH AS CLIMBING STAIRS, IRONING, CUTTING GRASS, DANCING, LIFTING CHILDREN, ETC?

_____

_____

9. IF YOU ARE A STUDENT, LIST THE TIME LOST FROM SCHOOL:

_____

10. PERIOD OF TIME YOU WERE CONFINED TO YOUR HOUSE: _____

_____

WORK BACKGROUND

1. PRESENT JOB TITLE: _____

2. NAME, ADDRESS AND TELEPHONE NUMBER OF EMPLOYER:

_____

3. PRESENT JOB TITLES AND DUTIES: _____

_____

4. HOW LONG HAVE YOU WORKED AT THIS JOB? _____

5. PRESENT SALARY: _____

6. PLEASE ATTACH COPIES OF FIVE RECENT PAY CHECK STUBS.

7. PLEASE ATTACH COPIES OF YOUR LAST FIVE FEDERAL AND STATE INCOME TAX RETURNS INCLUDING W-2'S.

8. PLEASE LIST YOUR EDUCATION AND DEGREES INCLUDING THE INSTITUTIONS YOU ATTENDED AND THE DATES YOU RECEIVED YOUR DEGREES. _____

_____

_____

9. WERE YOU IN THE COURSE OF YOUR EMPLOYMENT AND/OR PERFORMING YOUR JOB DUTIES WHEN THE ACCIDENT HAPPENED? _____

IF YES, WAS YOUR EMPLOYER NOTIFIED OF THE ACCIDENT? _____

IF YES, WHO WAS NOTIFIED? _____

10. NAME, ADDRESS, TELEPHONE NUMBER, POLICY NUMBER AND CLAIM NUMBER OF YOUR EMPLOYER'S WORKERS COMPENSATION INSURANCE COMPANY IF KNOWN: _____
_____

11. SHOULD A WORKERS COMPENSATION CLAIM BE FILED? _____

12. IF NOT WORKING FOR THIS EMPLOYER AT THE TIME OF YOUR ACCIDENT, STATE THE FOLLOWING:

NAME OF EMPLOYER: _____

ADDRESS: _____

JOB TITLE & TYPE OF WORK: _____

RATE OF PAY: _____

HOURS PER WEEK REGULARLY WORKED: _____

13. WHAT DID YOU EARN IN THE YEAR BEFORE YOUR ACCIDENT TOOK PLACE: _____

MEDICAL HISTORY BEFORE ACCIDENT

1. NAME AND ADDRESS OF FAMILY PHYSICIAN: _____

_____

2. HAVE YOU HAD ANY HEALTH PROBLEMS (IT IS IMPORTANT THAT WE KNOW THIS INFORMATION BECAUSE THE RECORDS OF ANY PHYSICIAN YOU HAVE SEEN IN THE PAST YEARS WILL PROBABLY BE SUBPOENAED BY THE DEFENSE) AS TO EACH HEALTH PROBLEM, PLEASE STATE THE FOLLOWING:

A. DESCRIBE THE HEALTH PROBLEM: _____

B. DATES EACH CONDITION WAS ACTIVE: _____

C. NAME & ADDRESS OF EACH TREATING PHYSICIAN:

_____

_____

D. KIND OF TREAMENT RENDERED: _____

E. IF HOSPITALIZED AS A RESULT LIST WHERE & WHEN:

_____

F. ARE YOU STILL UNDER TREATMENT OR MEDICAITON, IF SO, DESCRIBE:

_____

3. HAVE YOU EVER BEEN INJURED IN THE PAST? _____
IF SO, PLEASE GIVE THE DETAILS:

A. NATURE OF INJURY: _____

B. DATE: _____

C. HOW WERE YOU INJURED? _____

D. WHERE? _____

E. NAME & ADDRESS OF EACH TREATING PHYSICIAN:
_____

4. LIST BELOW WHAT NORMAL ACTIVITIES, INCLUDING SPORTS, HOBBIES, OR OTHER ACTIVITIES, YOU REGULARLY ENJOYED IN THE LAST THREE YEARS REGARDLESS OF WHETHER OR NOT YOU NOW PERFORM THOSE ACTIVITIES:

_____

_____

_____

PRIOR CLAIMS

1. IF YOU WERE INVOLVED IN ANY TYPE OF ACCIDENT RESULTING IN A CLAIM MADE BY YOU, PLEASE STATE THE FOLLOWING:

A. WHEN & WHERE WAS EACH CLAIM OR SUIT MADE? _____
_____

B. TYPE OF CLAIM MADE: _____

C. NAME & ADDRESS OF ATTORNEY: _____

D. WAS SUIT INSTITUTED? _____

E. AMOUNT OF SETTLEMENT OR VERDICT: _____

F. DATE CASE CLOSED: _____

OTHER EXAMINING PHYSICIANS

1. OTHER THAN AS STATED PREVIOUSLY, HAVE YOU EVER BEEN EXAMINED BY ANY PHYSICIAN FOR ANY OTHER REASON IN THE PAST TEN YEARS? IF SO, STATE THE NAMES AND ADDRESSES OF THE PHYSICIAN AND THE REASON FOR THE EXAM:

_____

_____

_____

POLICE RECORD

1. HAVE YOU EVER BEEN CONVICTED OF A CRIME? _☐_ YES _☐_ NO
   IF SO, STATE:

DATE	PLACE	CHARGES	RESULT

_____

2. IS THERE NOW OR HAS THERE EVER BEEN A RESTRICTION ON YOUR DRIVER'S LICENSE? _☐_ YES _☐_ NO

DETAILS: _____

CONCLUSION

IN COMPLETING THIS QUESTIONNAIRE, HAVE YOU THOUGHT OF ANY INFORMATION WHICH WE HAVE NOT ASKED WHICH MAY BE OF SOME ASSISTANCE TO US IN SERVING YOU/ IF SO, PLEASE STATE IT HERE, NO MATTER HOW SILLY, TRIVIAL OR EMBARRASSING IT MAY SEEM.

_____

_____

_____

I HAVE READ THE ABOVE STATEMENTS
AND THEY ARE TRUE AND CORRECT.

_____
CLIENT