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MALPRACTICE CONFIDENTIAL CLIENT INFORMATION FORM

This questionnaire is a confidential questionnaire for the use of our office only in preparing your claim for malpractice. Please answer every question fully and accurately. As your attorneys, we must know all about you and your case. If we are unaware of a fact because of an incorrect or incomplete answer, that response could cause you to lose your case.

PLAINTIFF'S INFORMATION

1. Full name: _____

   Address: _____

   Place of birth: _____

   Spouse, if applicable: _____

   Date of Marriage: _____

   Date of Divorce: _____

Children/Dependents (minors under 18 years old in your home):

a. Name: _____
   Date of birth: _____

b. Name: _____
   Date of birth: _____

c. Name: _____
   Date of birth: _____

If you are filling out this form on behalf of the Plaintiff, please provide your information:

Full name: _____

Address: _____

Phone number: _____

Relationship to Plaintiff: _____

CASE INFORMATION

2. On what date did you first encounter Defendant(s)? If there is more than 1 Defendant, please list each separately.

a. Defendant #1: _____

Date first seen: _____

b. Defendant #2: _____

Date first seen: _____

c. Defendant #3: _____

Date first seen: _____

d. Defendant #4: _____

Date first seen: _____

3. Please describe what happened and why you believe it was negligent.

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

3. For what reason did you first consult the Defendant?

_____

_____

_____

4. What medical history did you give to the Defendant?

_____

_____

5. Describe the first examination by Defendant.

6. As detailed as possible, please list, in date order, your recollection of encounters with Defendants and treatment given.

7. Name each Defendant you believe was negligent and state what he/she did, or did not do, that you believe constitutes negligence?

WITNESSES – FAMILY AND FRIENDS

8. List three to five **family members** who can best explain how the injuries from the claim have affected the Plaintiff's life:

a. Name: _____

Relationship to you: _____

Address: _____

b. Name: _____

Relationship to you: _____

Address: _____

c. Name: _____

Relationship to you: _____

Address: _____

d. Name: _____

Relationship to you: _____

Address: _____

e. Name: _____

Relationship to you: _____

Address: _____

9. List three to five **non-family members** (co-workers, friends, neighbors, etc.) who can best explain how the injuries from the claim have affected the Plaintiff's life.

a. Name: _____

Relationship to you: _____

Address: _____

b. Name: _____

Relationship to you: _____

Address: _____

c. Name: _____

Relationship to you: _____

Address: _____

d. Name: _____

Relationship to you: _____

Address: _____

e. Name: _____

Relationship to you: _____

Address: _____

FACT WITNESSES - NOT FAMILY OR FRIENDS

10. List all people ***(medical personnel, drivers, WHO ELSE?)*** who know facts about the situation involving malpractice:

a. Name: _____

Relationship to you: _____

Address: _____

Phone: _____

b. Name: _____

Relationship to you: _____

Address: _____

Phone: _____

c. Name: _____

Relationship to you: _____

Address: _____

Phone: _____

d. Name: _____

Relationship to you: _____

Address: _____

Phone: _____

e. Name: _____

Relationship to you: _____

Address: _____

Phone: _____

MEDICAL BACKGROUND

DEFENSE WILL OBTAIN YOUR RECORDS FROM ALL PAST MEDICAL PROVIDERS. PLEASE BE AS THOROUGH AS POSSIBLE WHEN ANSWERING THIS QUESTION.

11. **For the last ten years**, list every **hospital** admission for Plaintiff.

a. Hospital: _____

Address: _____

Dates of Admission: from: _____ to: _____

Reason for Admission: _____

b. Hospital: _____

Address: _____

Dates of Admission: from: _____ to: _____

Reason for Admission: _____

c. Hospital: _____

Address: _____

Dates of Admission: from: _____ to: _____

Reason for Admission: _____

d. Hospital: _____

Address: _____

Dates of Admission: from: _____ to: _____

Reason for Admission: _____

12. **For the last ten years**, have you undergone a physical examination in connection with your employment or any application for employment? If so, please provide copies.

_____ Yes _____ No

13. **Separate from this incident**, have you ever suffered from other disease or injury?

_____

_____

_____

_____

_____

_____

14. **For the last ten years**, please list primary (family) doctors you have treated with. List any conditions your primary doctor has treated you for.

a. Primary Care Doctor: _____

   Address: _____

   Phone Number: _____

   Conditions treated: _____

   _____

b. Primary Care Doctor: _____

   Address: _____

   Phone Number: _____

   Conditions treated: _____

   _____

c. Primary Care Doctor: _____

   Address: _____

   Phone Number: _____

   Conditions treated: _____

   _____

15. **For the last ten years**, please list all other healthcare providers you have consulted or treated with.

a. Doctor: _____

   Address: _____

   Phone Number: _____

Medical Issue: _____

Type of Treatment: _____

b. Doctor: _____

Address: _____

Phone Number: _____

Medical Issue: _____

Type of Treatment: _____

c. Doctor: _____

Address: _____

Phone Number: _____

Medical Issue: _____

Type of Treatment: _____

d. Doctor: _____

Address: _____

Phone Number: _____

Medical Issue: _____

Type of Treatment: _____

e. Doctor: _____

Address: _____

Phone Number: _____

Medical Issue: _____

Type of Treatment: _____

16. Has any Defendant, healthcare provider, or any medical professional advised you that someone made a mistake or committed malpractice? If so, please explain what they said and state the names, addresses, and phone numbers of the individual(s):

_____

_____

_____

_____

_____

_____

17. Have you ever made a claim or filed a lawsuit against anyone arising out of any sort of personal injury? If so, please complete the following.

a. **Date** and **location** of injury: _____

_____

b. What town/county was the lawsuit filed in? _____

c. When was your lawsuit filed? _____

d. Name and address of attorney: _____

e. Nature and extent of injury: _____

_____

f. Docket or claim number: _____

g. Amount of settlement or verdict: _____

h. Date case was closed: _____

DAMAGES

THE AMOUNT OF RECOVERY IS AFFECTED BY THE DAMAGES AND EXPENSES INCURRED AS A RESULT OF THE MALPRACTICE. IT IS IMPORTANT THAT YOU FULLY LIST ALL INFORMATION REGARDING THE PLAINTIFF'S INJURIES AND EXPENSES AS A RESULT OF THIS MALPRACTICE

18. State in detail all injuries received due to the negligence. (Physical condition and limitations, scars, deformities, headaches, stress, mental health, pains, limitations, discoloration, surgeries, future medical care, medicines, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

19. **Other than Defendants,** list all medical providers Plaintiff treated with for the injuries suffered relating to the malpractice. If applicable, please include additional hospitalizations, physical therapists, mental health therapists, counselors, etc.

a. Doctor/Hospital/Therapist: _____

   Address: _____

   Phone Number: _____

b. Doctor/Hospital/Therapist: _____

   Address: _____

   Phone Number: _____

c. Doctor/Hospital/Therapist: _____

   Address: _____

   Phone Number: _____

d. Doctor/Hospital/Therapist: _____

   Address: _____

   Phone Number: _____

e. Doctor/Hospital/Therapist: _____

   Address: _____

   Phone Number: _____

20. Describe in detail how Plaintiff is still suffering from the physical effects of the Defendant’s negligence.

_____

_____

_____

_____

_____

Describe how the injuries have affected Plaintiff's interactions with family and friends, participating in hobbies, recreational activities, clubs, organizations, community service activities, and religious activities:

_____

_____

_____

_____

_____

List all activities which you have not been able to perform, or can only perform with difficulty, since the malpractice (such as caring for children, climbing stairs, cutting grass, doing laundry, grocery shopping, cooking, gardening, hobbies, sports, etc.)

_____

_____

_____

_____

_____

_____

_____

ECONOMIC DAMAGES

21. Did you lose time and pay from work due to the negligence? If so, please complete the following:

    Employment history for five (5) years prior to malpractice:

    a. Employer: _____

       Address: _____

       Job Title: _____

       Description: _____

       Income: _____

       Date started: _____

       Date stopped: _____

b. Employer: _____

Address: _____

Job Title: _____

Description: _____

Income: _____

Date started: _____

Date stopped: _____

22. Education History (most recent first):

a. Educational Institution: _____

Dates Attended: _____

Degree/Certification: _____

b. Educational Institution: _____

Dates Attended: _____

Degree/Certification: _____

c. Educational Institution: _____

Dates Attended: _____

Degree/Certification: _____

If Plaintiff's medical bills were paid by Medicare, Medicaid, and/or an ERISA-funded private health insurance plan, they are entitled to be repaid at the time of settlement.

23. Name of health insurance carrier: _____

Policy number: _____

Effective date: _____

24. Has Plaintiff received, or is he/she currently receiving, Medicare benefits of any kind?

_____ Yes _____ No

25. Has Plaintiff received, or is he/she currently receiving, Medicaid benefits of any kind?

_____ Yes _____ No

26. Has Plaintiff received, or is he/she currently receiving, Social Security Disability benefits?

_____ Yes _____ No

27. Will Plaintiff become eligible for Medicare in the next 2 years?

_____ Yes _____ No

SOCIAL MEDIA – WARNING!

Any information, pictures or videos posted on social networking sites and the internet may affect your claim. Even if your account is set to 'private', all information maybe shared or accessed during the discovery period of the lawsuit.

28. Please complete the following with your username(s): (Ex.: Facebook – Lomurro Law Firm)

Facebook: _____ Instagram: _____

Twitter: _____ LinkedIn: _____

Other sites Plaintiff belongs to:

a. _____

b. _____

c. _____

29. Have you ever been convicted of a crime? If so, state:

Date of offense: _____

Township of arrest: _____

Charge(s): _____

Disposition: _____

30. Is there now, or has there ever been, a restriction on Plaintiff's driver's license? If so, please explain.

_____

_____

_____

Do not delete anything from your profile(s) during the course of litigation. In all personal injury cases, all plaintiffs are required to preserve, maintain, and are instructed to NOT destroy, delete, alter, modify or misplace any information contained in their personal social networking profiles.

By signing below, I acknowledge that I will not destroy, delete, alter, modify, or 'misplace' any information contained in my social networking site accounts including but not limited to Facebook, Twitter, Instagram LinkedIn, or the like, throughout the course of this litigation.

Acknowledged by: _____

CONCLUSION

Please use the below space for any information you thought of which we have not asked above. If you believe the information may be of some assistance to us in serving you, 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 TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature Date

PLEASE PROVIDE:

1. Copies of discs containing radiological testing (i.e., x-rays, CT-scans, MRIs, etc.).

2. Copies of any documents provided by Defendants (i.e., pamphlets, folders, explanatory documents, summary notes, e-mails, text messages, etc.)

3. Copies of any medical records in your possession.

4. Photographs and videos of Plaintiff **prior** to malpractice showing him/her with family members, being active, participating in events/organizations, enjoying hobbies/activities/life, and demonstrating activity levels.

5. Photographs and videos of victim **after** malpractice. Please provide any photographs or video demonstrating limitations, suffering, scarring, bruising, etc.

6. Copies of any calendars, diaries, lists, written notes, or other documents describing appointments, injuries, conversations about malpractice, emotional effects from malpractice, events missed because of malpractice, etc.

7. Copy of Plaintiff's Medicare, Medicaid, and/or health insurance card.

8. Copies of any bills and expenses incurred because of the malpractice.

IF YOU ARE MAKING A CLAIM FOR LOST WAGES, PLEASE PROVIDE:

9. Five recent pay stubs.

10. Five most recently filed state and federal tax returns, including W-2s.