
Referring Attorney

CLIENT'S PERIODIC CONFIDENTIAL REPORT TO ATTORNEY

CLIENT'S NAME: _____ DATE: _____

You should fill out this report and mail it to us promptly. Answer all questions fully. Please write on the printed side of these pages only. If more writing space is needed, attach another paper, identify the question by number, write on one side of the page only. All questions are with regard to the injuries received in this accident. (If the injured client is a minor, this report should be filled out by the parent of the child).

1. ARE YOU STILL ACTIVELY TREATING WITH ANY DOCTOR OR PHYSICAL THERAPIST? () YES () NO

2. IF YOU ANSWERED "YES" TO THE ABOVE QUESTION, PLEASE LIST THE NAME OF EACH DOCTOR AND/OR THERAPIST YOU ARE STILL SEEING:

DOCTOR: _____ DOCTOR: _____

DOCTOR: _____ THERAPIST: _____

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

_____ MEDICARE/MEDICAID

_____ CAR INSURANCE COMPANY

_____ HEALTH INSURANCE COMPANY

_____ OTHER: _____ (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.

4. A. HAVE YOU BEEN UNABLE TO PERFORM YOUR NORMAL OCCUPATION OR JOB FOR ANY PERIOD OF TIME? YES () NO ()

B. IF YOU ANSWERED "YES" ABOVE, SET FORTH THE DATES WHEN YOU WERE UNABLE TO PERFORM YOUR NORMAL OCCUPATION OR JOB:

FROM: _____ TO: _____

5. IF YOU ANSWERED "YES" TO QUESTION 4A ABOVE, ARE YOU CURRENTLY UNABLE TO PERFORM YOUR NORMAL OCCUPATION OR JOB?
YES () NO ()

6. IF YOU ANSWERED "YES" TO QUESTION 5 ABOVE, DESCRIBE IN DETAIL WHY YOU ARE CURRENTLY UNABLE TO PERFORM YOUR OCCUPATION OR JOB:

7. IF YOU ANSWERED "NO" TO QUESTION 5 ABOVE, STATE THE SPECIFIC DATE ON WHICH YOU RESUMED YOUR NORMAL OCCUPATION:

MONTH: _____ DAY: _____ YEAR: _____

8. ARE YOU UNABLE TO DO ANY OF THE ACTIVITIES IN WHICH YOU WOULD NORMALLY ENGAGE? YES () NO ()

9. IF YOU ANSWERED "YES" ABOVE, LIST ALL OF THE ACTIVITIES WHICH YOU ARE CURRENTLY UNABLE TO PERFORM:

10. SINCE THE LAST REPORT OR VISIT TO OUR OFFICE:

A. HAVE YOU SUFFERED ANY PAIN FROM YOUR INJURIES?
YES () NO ()

IF "YES", STATE:

WHERE THE PAIN WAS: _____

HOW OFTEN IT OCCURRED: _____

HOW LONG DID IT LAST? _____

WAS THE PAIN MILD, MODERATE OR SEVERE? _____

B. DID YOU TAKE ANY HOME TREATMENTS, SUCH AS: HEAT LAMP, ELECTRIC PAD, HOT WATER BOTTLE, HOT BATHS, SHOWER, MASSAGE OR SPECIAL EXERCISES? YES () NO ()

IF "YES", DESCRIBE THE TREATMENT AND HOW OFTEN TAKEN:

C. HAVE YOU TAKEN ANY MEDICINE FOR YOUR PAIN OR INJURIES?
YES () NO ()

IF "YES" WHAT DID YOU TAKE AND HOW OFTEN? _____

D. HAVE YOU HAD ANY ADDITIONAL AUTOMOBILE, SLIP AND FALL OR OTHER ACCIDENTS, OR OTHER INJURIES? YES () NO ()

E. DO YOU BELONG TO ANY SOCIAL NETWORKING SITES (e.g., Facebook, Twitter, Instagram, LinkedIn, SnapChat, etc.), OR IF YOU PREVIOUSLY ADVISED US OF AN ACCOUNT, HAVE YOU UPDATED YOUR ACCOUNT?

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.

11. IN THE SPACE BELOW, PLEASE WRITE A BRIEF DESCRIPTION OF ALL COMPLAINTS OR PROBLEMS THAT YOU STILL HAVE FROM YOUR ACCIDENT:

12. PLEASE INDICATE ANY CHANGE OF ADDRESS OR PHONE NUMBER:

13. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW? IF SO, STATE IT HERE:

SIGNED: _____