

PERSONAL INJURY CLIENT INTERVIEW SHEET

FILE NO. _____ D/I _____ SOL _____ TYPE CASE _____

OPENED _____ SOURCE _____ LAWYER ____/____ LA _____

CLIENT INFORMATION:

NAME (First, Middle, Last) _____ NAME CALLED _____

CLIENT GUARDIAN (If Minor) _____ NONCUSTODIAL PARENT _____

CLIENT MAILING ADDRESS _____ STREET ADDRESS (If Different) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

OTHER PHONE _____ NAME & RELATIONSHIP _____

AGE _____ EDUCATION _____

CLIENT D.O.B. _____ CLIENT SS NO. _____

MARITAL: Married/Single/Divorced/Widowed/Separated _____

Date

SPOUSE/PARENT GROUP INSURANCE Y/N _____

Company

OTHER HEALTH INSURANCE/MEDICARE/MEDICAD _____

Company

CRIMINAL RECORD _____

WORK INFORMATION:

CLIENT'S EMPLOYER _____ DATE EMPLOYED _____

EMPLOYER'S ADDRESS (Street, City, State, Zip) _____

LOST WAGES Y/N JOB TITLE _____ RATE OF PAY _____

HRS/WK _____ SHIFT/HOURS _____ SUPERVISOR _____

STD/LTD/SICK PAY Y/N _____

Company

GROUP INSURANCE Y/N _____
Company

HOST VEHICLE INSURANCE:

HOST VEHICLE INSURANCE COMPANY _____ AGENT

ADJUSTER _____ PHONE NUMBER _____

INSURANCE COMPANY ADDRESS _____

INSURED'S NAME _____ CLAIM NUMBER _____ POLICY NUMBER _____

CLIENT STATUS: Driver _____ Permissive User _____ Passenger _____ Owner _____
Insured _____ Resident Relative _____ Pedestrian _____

PIP Y / N \$ _____ MED PAY Y / N \$ _____ COLLISION Y / N _____
UIM Y / N \$ _____ UM \$ _____ RENTAL Y / N _____
Filed

CLAIM REPORTED Y / N Date Reported _____

OTHER VEHICLE INSURANCE – HOUSEHOLD/PERSONAL:

VEHICLE 1:

MAKE/MODEL _____ OWNER/RELATIONSHIP _____

AGENT _____ COMPANY _____

VEHICLE 2:

MAKE/MODEL _____ OWNER/RELATIONSHIP _____

AGENT _____ COMPANY _____

OTHER: _____

ADVERSE PARTY INSURANCE NO. 1:

INSURANCE COMPANY		AGENT
ADJUSTER	PHONE NUMBER/EXT	
INSURANCE COMPANY ADDRESS		
INSURED	POLICY NUMBER	CLAIM NUMBER

ADVERSE PARTY NO. 2:

NAME (First, Middle, Last) _____

ADDRESS _____

D.O.B _____ MINOR Y/N PHONE NUMBER _____

ADVERSE PARTY INSURANCE NO. 2:

INSURANCE COMPANY		AGENT
ADJUSTER	PHONE NUMBER/EXT	
INSURANCE COMPANY ADDRESS		
INSURED	POLICY NUMBER	CLAIM NUMBER

ACCIDENT INFORMATION:

DATE OF ACCIDNET _____ TIME _____ POLICE REPORT Y/N _____

Highway Patrol _____ County _____ City _____

Specify Specify

CLIENT STATUS: Driver _____ Passenger _____ Pedestrian _____

If passenger or pedestrian, driver's name _____

LOCATION OF ACCIDENT _____

DESCRIBION OF ACCIDENT _____

PARTY CHARGED _____ ETOH _____ AL/AP

WITNESSES/PASSENGERS

HOST VEHICLE:

YEAR _____ MAKE _____ MODEL _____

TAG NUMBER _____ VEHICLE DESCRIPTION _____

DAMAGE DESCRIPTION _____

TOWED _____ LOCATION _____

OWNER _____ RENTAL _____

ADVERSE PARTY VEHICLE:

YEAR _____ MAKE _____ MODEL _____

TAG NUMBER _____ VEHICLE DESCRIPTION _____

DAMAGE DESCRIPTION _____

TOWED _____ LOCATION _____

OWNER _____

CLIENT INJURIES:

INJURIES _____

EMERGENCY ROOM Y / N _____

X-RAYS _____ Hospital
RX _____

DOCTOR 1 _____

DOCTOR 2 _____

DOCTOR 3 _____

OTHER _____

DRUG ACCOUNT: HW _____ SMITHS 1 _____ SMITHS 2 _____

EMS OR RESCUE SQUAD

EYEGASSES BROKEN _____ YES _____ NO

CLIENT PRIOR MEDICAL/CLAIM HISTORY:

FAMILY DOCTOR _____

PRIOR CLAIMS _____

PRIOR MEDICAL PROBLEMS _____