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 _____
Filed
UIM Y / N $_____ UM $_____ RENTAL Y / N

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 _____

Hospital

X-RAYS _____ RX _____

DOCTOR 1 _____

DOCTOR 2 _____

DOCTOR 3 _____

OTHER _____

DRUG ACCOUNT: HW _____ SMITHS 1 _____ SMITHS 2 _____

EMS OR RESCUE SQUAD

EYEGLASSES BROKEN _____ YES _____ NO

CLIENT PRIOR MEDICAL/CLAIM HISTORY:

FAMILY DOCTOR _____

PRIOR CLAIMS _____

PRIOR MEDICAL PROBLEMS _____

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