PERSONAL INJURY/AUTO ACCIDENT
INTAKE SHEET

SOL:

INITIAL CLIENT STATEMENT

TODAY'S DATE: _____

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE?_____

IF SO, PLEASE GIVE NAME OF ATTORNEY : _____

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? _____

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC...)

_____

PERSONAL INFORMATION:

NAME: _____

Address: _____

Telephone Number:(home) _____

Email Address:_____

Age:___ Date of Birth:_____ Social Security No:_____

Texas Driver's License Number: _____

Military Service: _____

EMPLOYER: _____

Address: _____

Telephone Number:(work)_____

Occupation:_____ Worked there how long?_____

Immediate Supervisor:_____

SPOUSE'S NAME: _____

Address: _____

Telephone Number:(home) _____

Employer: _____

Employer's Address: _____

Telephone Number:(work)_____ Occupation _____ Age:___ Date of Birth:_____ Social

Security No:_____

CHILDREN:

Name(s)/Age(s):_____

_____

_____

How many children are living with you now? _____

EMERGENCY CONTACT:

Name: _____

Relationship:_____

Address:_____

City:_____ State_____ Zip_____

Telephone Number:_____

ACCIDENT INFORMATION:

Accident Date:_____ Day of Week:_____

Time:_____ am/pm

Cause No:_____Court:_____County:_____

Location:(Be Specific)_____

_____

Where were you coming from? _____

Where were you going? _____

DETAILS OF ACCIDENT:

Weather condition (if happened outside):_____

Any construction in the area? _____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC-- GET AS MUCH DETAIL AS POSSIBLE)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DIAGRAM OF HOW ACCIDENT OCCURRED.

Did police come to the scene? _____. If so, which jurisdiction (e.g., Houston, County Sheriff, Constable?) _____. Did they assign an incident number? _____ No. _____?

Was anyone ticketed? If so, whom, and for what? _____?

Were you driving an employer company vehicle?_____

What was the color, make, model and year of the vehicle ***YOU*** were driving?_____

_____

What was the license plate number of the vehicle you were driving? _____

What was the color, make, model and year of the ***OTHER*** vehicle?_____

_____

What was the license plate number of the other vehicle? _____

What was the name of the driver of the ***OTHER*** vehicle? _____

Was anyone, including yourself, to the best of your knowledge, taking any medication or using any sort of drugs? _____

_____

Had anyone, including yourself, been drinking?_____

Did anyone make a statement at the scene?_____

Who made such a statement, if any?_____

What was said?_____

_____

_____

To whom?_____

Were photographs taken of the scene?_____

DAMAGES & INJURIES:

MEDICAL INFORMATION:

Were you injured in this accident? Describe:_____

_____

Did you go to the hospital?____ Which hospital _____

Admitted or OPD?_____ If admitted, ***WHEN*** released: _____

X-Rays taken? _____ Were you taken by ambulance? _____

Are you under the care of a physician now? _____

Prior **similar injuries**, treated medical conditions and/or symptoms

to same area or current injury (Dates/Drs.):_____

Prior claims and/or settlements (types, dates, attorneys): _____

List any **prior injury settlements**:_____

How have your injuries changed your lifestyle:

Loss of consortium: _____

Sports: _____

Social Activities: _____

Job Duties: _____

Household Chores: _____

Have you had to hire domestic help? _____

How do you feel you have been damaged emotionally by these injuries? _____

How do you feel you have been damaged financially by these injuries? _____

Was anyone <u>else</u> injured? _____

Who was injured? _____

Describe Injury: _____

Did this injury occur when you were driving a vehicle? _____

What would you consider a satisfactory outcome to your claim? _____

<u>LIST DOCTORS</u>:

1. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you first see the doctor? _____

When did you last see the doctor? _____

When will you see him again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

2. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you first see the doctor? _____

When did you last see the doctor? _____

When will you see him again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

3. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When did you first see the doctor? _____

When will you see him again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

4. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When did you first see the doctor? _____

When will you see him again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

5. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you first see the doctor? _____

When did you last see the doctor? _____

When will you see him again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC., RECEIVED. NOTE USE OF CERVICAL COLLAR, CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING, OR WHEN CAST IS REMOVED.

OTHER:

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS

_____

_____

_____

_____

_____

_____

_____

_____

_____

WITNESSES:

1. NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Relationship (fellow employees, supervisors, bystanders, etc...)

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

2. NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Relationship (fellow employees, supervisors, bystanders, etc...)

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

3. NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Relationship (fellow employees, supervisors, bystanders, etc...)

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

4. NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Relationship (fellow employees, supervisors, bystanders, etc...)

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

5. NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Relationship (fellow employees, supervisors, bystanders, etc...)

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

VIEWING THE SCENE:

Can we go to the accident scene? _____

Is the equipment available for inspection? _____

Who do we contact to arrange a viewing? _____

NAME & ADDRESS:_____

_____

_____

Telephone Number:(___)_____

Job Title: _____

Can we photograph the equipment? _____

Any other information you feel may assist us in representing you for this claim? _____

_____

_____

_____

_____

_____

_____

_____

INSURANCE COVERAGE FOR PLAINTIFF (YOU)

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

_____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Do you have Personal Injury protection (PIP)?: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Cash Policy for Accidents: _____

Effective Dates of coverage: _____

Is this a WORKER'S COMP CLAIM? _____

Are you covered through your employer's insurance? _____

If so, provide company and agent, if known: _____

Policy or plan number: _____

Name of insured: _____

Limits of coverage: _____

Did you file a claim with your insurance company? _____

Has anyone from the insurance company contacted you about this claim? __ Name of Person who contacted you: _____

When was contact made? _____

If a statement was given, was it tape recorded or written? _____

Did you receive a copy? _____

Have you signed any authorizations to release information to anyone? _____

Have you signed any releases? _____

Have you received any insurance benefits? _____

Have you been judged partially or permanently disabled by any administrative agency as a result of this injury? _____

INSURANCE COVERAGE FOR DEFENDANT (OTHER PARTY)

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

_____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

EDUCATION:

High School/G.E.D.:_____Year of Graduation:_____

Technical School: _____

College/University:_____Years & Degree:_____

EMPLOYMENT HISTORY:

Employer:_____ Position:_____

Duties:_____

_____

Employer:_____ Position:_____

Duties:_____

_____

Employer:_____ Position:_____

Duties:_____

_____

Employer:_____ Position:_____

Duties:_____

_____

OTHER:

Do you have any criminal history within the last ten (10) years? If so, please explain in full: ____

_____

_____

_____