

For Office Use Only:	
Fee Agmt. Provided	Y or N
Deposit Amount:	_____
Upcoming Court Date:	_____
Attorney:	_____ Referred By: _____

**INITIAL INTERVIEW FORM
Personal Injury/Auto Collision**

TODAY'S DATE: _____ ATTORNEY: _____

DATE OF INCIDENT: _____

COURT DATE AND TIME: _____

REFERRED BY: _____

PERSONAL INFORMATION:

FULL LEGAL NAME: _____

ALIAS(ES): _____ NICKNAME: _____

DATE OF BIRTH: _____ SSN: _____

ADDRESS: _____

CITY/COUNTY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____

CITY/COUNTY: _____ STATE: _____ ZIP: _____

LIVE WITH: _____ CHILDREN? _____ NO. _____

HOME PHONE NO. _____ CELL PHONE NO. _____

WORK PHONE NO. _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Address: _____

Phone: _____

EDUCATION:

Highest level completed: _____ Year of Graduation: _____

Technical School: _____

EMPLOYMENT:

EMPLOYER NAME: _____

ADDRESS: _____

PHONE NO. _____ SUPERVISOR: _____

HOURS AT WORK: _____ DAYS YOU WORK: _____

LENGTH OF EMPLOYMENT: _____ JOB TITLE: _____

YOUR ACCOUNT OF WHAT HAPPENED: _____

PRIOR SIMILAR INJURIES:

Treated medical conditions and/or symptoms to the same area of current injury. (Include dates and Doctors): _____

PRIOR CLAIMS AND/OR SETTLEMENTS: (Type, Date and Attorney)

COLLISION INFORMATION:

Date of Incident: _____

Time: _____

Location: _____

Traveling from: _____

Traveling To: _____

Weather Conditions: _____

Construction Zone: Yes No

Description of Incident: _____

Personal Vehicle: Yes No

Company Vehicle: Yes No

Where were you seated at time of incident? _____

Your Vehicle:

Make _____ Model _____ Year _____

Other Vehicle:

Make _____ Model _____ Year _____

Are you aware of any person taking any medication or drugs prior to this incident? Y / N

If so, who? _____

Are you aware of any person consuming alcoholic drinks prior to the incident? Y / N

If so, who? _____

Did you ingest any medication, drugs, or alcoholic drinks prior to the incident? Y / N

If yes, what type and when? _____

Did you or anyone make a statement at the scene? Y / N

Who made the statement? _____

What was said? _____

Who else witnessed the statement? _____

Were photographs of the scene taken? Y / N

Who took photographs? _____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone Number: _____

Collision Coverage Amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage: _____

Cash Policy for Accidents: _____

Effective Dates of Coverage: _____

Is this a Worker's Compensation Claim? Y / N

Are you covered through your employer's insurance? Y / N

If so, then provide employer's insurance information: _____

Have you filed a claim with your insurance company? Y / N

Have you been contacted by anyone from an insurance company? Y / N

If so, provide name and contact information of person who contacted you: _____

INSURANCE COVERAGE FOR DEFENDANT:

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Claim Number: _____

Agent's Name and address: _____

Collision Coverage Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Medical Information:

Were you injured in the incident? Y / N

Describe Injury: _____

Transported via ambulance? Y / N

Treated at Hospital? Y / N

Which Hospital? _____

Admitted Patient or Out-Patient (circle one)

If admitted, what was your release date? _____

Are you currently under the care of a physician? Y / N

List of Treatment Providers:

Name: _____

Address: _____

Phone: _____

Dates of Treatment: _____

Name: _____

Address: _____

Phone: _____

Dates of Treatment: _____

Olmstead & Olmstead, P.C.

Rev. 12/15

Initial Consultation Form (Personal Injury/Auto Collision)

Disclaimer: This form provided at www.olmsteadlawyers.com is designed to provide general information to the public and is not intended to offer legal advice. The firm does not intend to create an attorney-client relationship by offering this information and use of any information given on this site shall not be deemed to create an attorney-client relationship. If you wish to inquire about the firm's services, please contact us.

Name: _____

Address: _____

Phone: _____

Dates of Treatment: _____

Name: _____

Address: _____

Phone: _____

Dates of Treatment: _____

Name: _____

Address: _____

Phone: _____

Dates of Treatment: _____

PRESCRIPTIONS AND MEDICAL EQUIPMENT:

Medications: _____

Medical Equipment: _____

OTHER PERSONS INJURED:

WITNESSES:

Name & Address: _____

Phone: _____

Relationship to Plaintiff: _____

Describe what witness observed: _____

Name & Address: _____

Phone: _____

Relationship to Plaintiff: _____

Describe what witness observed: _____

Name & Address: _____

Phone: _____

Relationship to Plaintiff: _____

Describe what witness observed: _____

Name & Address: _____

Phone: _____

Relationship to Plaintiff: _____

Describe what witness observed: _____

Name & Address: _____

Phone: _____

Relationship to Plaintiff: _____

Describe what witness observed: _____

Other Relevant Information: _____
