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: _____

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: _____

_____

_____

_____