

**NEW CASE INFORMATION**

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D/FILE OPENING: \_\_\_\_\_

D/ACCIDENT: \_\_\_\_\_

SOL: \_\_\_\_\_

NATURE OF CASE: \_\_\_\_\_

OTHER DEADLINE: \_\_\_\_\_

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**CLIENT DATA**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. #: \_\_\_\_\_

CITY, ST, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

OTHER PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_

- a. Any restrictions? \_\_\_\_\_
- b. Any citations, including DUI, in the last 3 years? \_\_\_\_\_  
\_\_\_\_\_

EMPLOYER: \_\_\_\_\_

- a. How long? \_\_\_\_\_
- b. Occupation? \_\_\_\_\_
- c. Rate of Pay? \_\_\_\_\_
- d. Time lost from work? \_\_\_\_\_
- e. Fringe benefits lost? \_\_\_\_\_
- f. Date returned to work? \_\_\_\_\_
- g. Any work limitations? \_\_\_\_\_

Marital Status: (check one)

Single

Married

Separated

Divorced

- a. Spouse's name: \_\_\_\_\_
- b. Spouse's employer: \_\_\_\_\_
- c. Work phone: \_\_\_\_\_

**ACCIDENT DATA**

Do you have a copy of the accident report? \_\_\_\_\_

# injured in client's vehicle: \_\_\_\_\_

a. Name(s): \_\_\_\_\_  
\_\_\_\_\_

Wearing seatbelts? \_\_\_\_\_

Was accident job-related? \_\_\_\_\_

a. If yes, is Workers' Comp paying your medical bills?  
\_\_\_\_\_

b. If yes, name, address & phone # of Workers' Comp benefits provider:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Property Damage: \_\_\_\_\_

Have you given a statement about the collision to anyone? \_\_\_\_\_

a. If yes, to whom did you give the statement? \_\_\_\_\_  
\_\_\_\_\_

b. Name, address & phone # of insurance company: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Was your statement recorded? \_\_\_\_\_

d. Have you signed any documents provided by the above – identified person or  
insurance company? \_\_\_\_\_

Has the adjuster discussed settlement of your person injury claim? \_\_\_\_\_

Amount offered: \$ \_\_\_\_\_

Has the adjuster discussed settlement of your property damage claim? \_\_\_\_\_

Amount offered: \$ \_\_\_\_\_

Present location of the vehicle: \_\_\_\_\_

Legal owner of the vehicle: \_\_\_\_\_

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**CLIENT'S INSURANCE INFORMATION**

Client's insurance company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Uninsured Motorist limits: \$ \_\_\_\_\_

Medical Payment benefits: \$ \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_

Other auto insurance: \_\_\_\_\_

Hospitalization/Health insurance: \_\_\_\_\_

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**MEDICAL INFORMATION**

Health prior to accident: \_\_\_\_\_

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Prior hospitalizations: (Please include year, facility & reason for hospitalization, i.e. surgery, illness)

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Prior illnesses: \_\_\_\_\_

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Broken bones? (If yes, when?) \_\_\_\_\_

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Prior neck and/or back problems? (If so, when? Who treated you?) \_\_\_\_\_

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Have you ever suffered prior injury to any part of your body which was injured in this accident?  
(If yes, what was injured? When? Who treated you?) \_\_\_\_\_

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Which physicians and/or facilities have treated you thus far for the injured you sustained as a result of this collision? (Please provide name and address, if possible)

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**MISC. INFORMATION**

Any prior automobile accident? \_\_\_\_\_

a. If yes, when and where? \_\_\_\_\_

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b. Were you injured? \_\_\_\_\_

Any prior claims for damages? \_\_\_\_\_

a. Property damage? \_\_\_\_\_

b. Workers' Comp? \_\_\_\_\_

c. Other? \_\_\_\_\_

Any prior claims for personal injury? \_\_\_\_\_

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