

*"SORRY TO HEAR..."*

*"HOW ARE YOU FEELING?"*

*"WE CAN HELP WITH THAT..."*

**D:** \_\_\_\_\_ **P:** \_\_\_\_\_ **Ped:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_ **Source:** \_\_\_\_\_ **Type:** \_\_\_\_\_

Name: \_\_\_\_\_ M F DOA: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (Cell): \_\_\_\_\_ (W): \_\_\_\_\_ OK To Call? \_\_\_\_\_



Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

E-Mail : \_\_\_\_\_ @ \_\_\_\_\_ Check Regularly? \_\_\_\_\_

CDL: \_\_\_\_\_ Spouse Name: \_\_\_\_\_ OK To Discuss? \_\_\_\_\_

Nearest Relative: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### FACTS ABOUT THE ACCIDENT

Location: \_\_\_\_\_ Cross Street \_\_\_\_\_

Seat Belt? \_\_\_\_\_ Report Taken? \_\_\_\_\_ Police Dept? \_\_\_\_\_ Who was CITED? \_\_\_\_\_

Witnesses & Phone: \_\_\_\_\_

WHAT HAPPENED?  
WHAT HAPPENED?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did the defendant admit guilt or apologize?: \_\_\_\_\_

Did Body Hit Interior?: \_\_\_\_\_

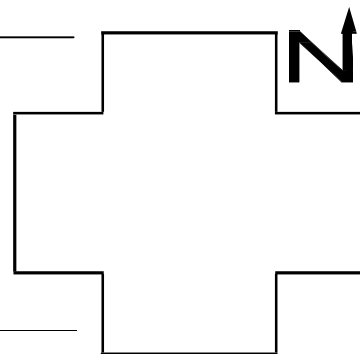
Client Car: Mk/model: \_\_\_\_\_ Year: \_\_\_\_\_ Plate #: \_\_\_\_\_

Describe Dents/Dam: \_\_\_\_\_

Where is car now? \_\_\_\_\_ Repair Est?: \_\_\_\_\_

Def. Car: Mk/model: \_\_\_\_\_ Year: \_\_\_\_\_ Plate # \_\_\_\_\_ Repair Est?: \_\_\_\_\_

**FULLY** Describe Dents/Dam: \_\_\_\_\_



## LOST WORK



Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Position: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Wage: \_\_\_\_\_

Time Off: \_\_\_\_\_

## INJURIES



Ambulance: \_\_\_\_\_ ER Room: \_\_\_\_\_ Overnight: \_\_\_\_\_ Describe Injuries and Pain/Complaints:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

All Providers To Date: Name, Address, Phone, Dates of Treatment:

Name	Address	Phone#	Dates of Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## MEDICAL HISTORY



Previous Auto Accident(s) : \_\_\_\_\_ Date(s): \_\_\_\_\_

Injuries: \_\_\_\_\_

Treatment: \_\_\_\_\_

Other Previous Injuries: \_\_\_\_\_

Work Comp Injury? \_\_\_\_\_ Injuries: \_\_\_\_\_

Treatment: \_\_\_\_\_

Ever See Chiropractor? \_\_\_\_\_ Ever See PT? \_\_\_\_\_

## FACTS ABOUT THE DEFENDANT

Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Address: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Hair: \_\_\_\_\_ Eyes: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Build: \_\_\_\_\_ Distinguishing Features: \_\_\_\_\_

Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

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

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_

Offered: \_\_\_\_\_

## FACTS ABOUT THE PLAINTIFF

Client Insurance: \_\_\_\_\_

U/M Limit: \_\_\_\_\_ Med Pay Limit: \_\_\_\_\_

Address: \_\_\_\_\_

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

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_

If client is passenger and/or is driving a borrowed vehicle

Insurance of driven vehicle: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

Health Insurer: \_\_\_\_\_

Address/Phone #: \_\_\_\_\_

**$\pi$**

Medical Identification #: \_\_\_\_\_

Prior Attorney Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date Represented: \_\_\_\_\_ Address: \_\_\_\_\_

**Patient Name**\_\_\_\_\_

**Date of Injury**\_\_\_\_\_

**Patient Complaints (Check all that apply)**

- ☐ Neck pain
- ☐ Lower back pain
- ☐ Headaches
- ☐ Muscle spasm at \_\_\_\_\_
- ☐ Numbness in \_\_\_\_\_
- ☐ Tingling in \_\_\_\_\_
- ☐ Contusion (bruising) \_\_\_\_\_
- ☐ Radiating pain to \_\_\_\_\_
- ☐ Restriction of motion of \_\_\_\_\_
- ☐ Blurred vision
- ☐ Anxiety/Depression
- ☐ Fracture of \_\_\_\_\_
- ☐ Scarring of \_\_\_\_\_
- ☐

Other: \_\_\_\_\_

## Treatment History

- ☐ Medication prescribed
- ☐ Immobilization (collar, brace)
- ☐ MRI scan
- ☐ CT scan
- ☐ Injections
- ☐ Other:

Other: \_\_\_\_\_

## Disability

- ☐ Placed on disability from \_\_\_\_\_ to \_\_\_\_\_

Additional  
Information:

## Additional

[illegible]