SOL:____________

PERSONAL INJURY/AUTO ACCIDENT INTAKE SHEET

INITIAL CLIENT STATEMENT

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: ______________
City: ______________ State: ____________ Zip Code: ______________
Telephone Number: (home) ______________
Pager Number:______________Cell Number:______________
Age: _____ Date of Birth: ________ Social Security No: ______________
Driver's License No.: ______________

EMPLOYER: ______________
Address: ______________
Telephone Number: (work)______________
Occupation: __________ Worked there how long?______________
Immediate Supervisor: ______________

ACCIDENT INFORMATION:
Accident Date: ___________ Date of Week: ______________
Time: ___________ am/pm
Location: (Be Specific)______________
____
Where were you coming from? ______________
Where were you going? ______________
Who investigated the scene (HPD, Sheriff's Department, etc.)?______________

DETAILS OF ACCIDENT:
Weather condition (if happened outside): ______________
Any construction in the area? ______________
DESCRIPTION OF ACCIDENT: (BE SPECIFIC-- GET AS MUCH DETAIL AS POSSIBLE)______________
____
____

Did this injury occur when you were driving a vehicle?______________
Were you driving a company vehicle?______________
What was the make, model and year of the vehicle you were driving?______________
____

What was the make, model and year 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?_______________________________________

INSURANCE COVERAGE FOR PLAINTIFF:

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: _______________________________________

INSURANCE COVERAGE FOR DEFENDANT:

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: _______________________________________

Personal Injury Protection Amount:____

MEDICAL INFORMATION:

Were you injured in this accident? ________ Describe: ___________________________

____

____

____

Did you go to the hospital? ____

Which hospital ____

Admitted or Out Patient? ____

If admitted, release date: ____

X-Rays taken? _____ Were you taken by ambulance? ______________________
Are you under the care of a physician now? ______________________

LIST DOCTORS:

1. Name: ______________________ Phone: ______________________
   Address: ______________________
   ____
   Telephone Number: ______________________
   When did you last see the doctor? ______________________
   When will you see the doctor again? ______________________
   Physical therapy? ______________________
   Current Balance on Medical Bills: ______________________
2. Name: ______________________ Phone: ______________________
   Address: ______________________
   ____
   Telephone Number: ______________________
   When did you last see the doctor? ______________________
   When will you see the doctor again? ______________________
   Physical therapy? ______________________
   Current Balance on Medical Bills: ______________________
3. Name: ______________________ Phone: ______________________
   Address: ______________________
   ____
   Telephone Number: ______________________
   When did you last see the doctor? ______________________
   When will you see the doctor again? ______________________
   Physical therapy? ______________________
   Current Balance on Medical Bills: ______________________

Was anyone else injured? ______________________
Who was injured? ______________________
Describe Injury: ______________________
____

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

____
____
____
____