



Personal Injury Client Interview Sheet

Date: _____

1. **Personal Information:**

Name: _____

Address: _____

Phone: (Home): _____ (Cell): _____ (Work): _____

Employed at Time of Accident? YES NO

Occupation: _____

Employer: _____

Have you missed time from work due to the accident? YES NO How much time? _____

Do you estimate missing more work? YES NO If yes, how much time? _____

If a Minor

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

Custody with which Parent? MOTHER FATHER

2. **Accident Information:** (Skip to No. 3 if no vehicle was involved)

Was this a vehicle accident? YES NO Driver's License No.: _____

Date of Injury: _____ Time of Day: _____ AM PM

Location: _____

Weather Conditions: RAINY/WET FOGGY CLEAR Was it Dawn or Dusk? YES NO

Road Surface: _____

Were you the driver or passenger? DRIVER PASSENGER PEDESTRIAN OTHER _____

Were you wearing a seatbelt? YES NO N/A

General description of the accident: _____

General description of any injuries: _____

Described damage to vehicle (if any) _____

Were photos taken at the accident? YES NO Estimated Vehicle Damage: \$ _____

Insurance Company: _____

Policy No.: _____ Claim No. _____

3. **Report Information**

Was a police report filed? YES NO If yes, what police department/precinct? _____

What is the report no? _____ Name of reporting officer: _____

Were citations issued? YES NO Were drugs/alcohol involved? YES NO

Were there witnesses? YES NO

4. Injury Information

Date of Injury: _____ Time of Day: _____ AM PM

Location: _____

General description of the accident: _____

General description of any injuries: _____

Were photos taken of the injury? YES NO

5. Medical Information

Were you transported by ambulance? YES NO

Were you seen by physicians in the emergency room? YES NO

Were you required to stay in the hospital? YES NO

Describe any continued medical treatments or diagnoses relating to the accident: _____

Describe any effects from injuries that still exist: _____

Prior Medical Information

Did you have physical problems before the accident? YES NO

If yes, describe: _____

Have you been hospitalized in the past 10 years? YES NO

If yes, for what? _____

Have you been in previous accidents? YES NO

Year _____ Type of accident: _____

Injuries: _____

Health Insurance

Name of Health Insurance Provider: _____

Policy/Group No.: _____

6. Other Party's Information

Name: _____

Insurance Company: _____

Policy No.: _____ Claim No. _____