DODGE & VEGA PLC
ATTORNEYS AT LAW

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._____