CLIENT INTAKE FORM – AUTO ACCIDENT

Date Today: _____ Client's Name_____

Address: _____
Street City State Zip

Telephone: (H) _____ (W)_____ (C) _____

Date of Birth: _____ Place of Birth: _____ SSN: _____

Martial Status: _____ Dependents: _____ Owe Child Support? □ Yes □ No

Closest Relative(spouse)(Name): _____

Address/telephone: _____

Occupation: _____ Weekly Gross: _____ Length of Employment: _____

Employer's Name: _____

Employer's Address: _____

Describe Job Duties: _____

Accident Information

Name\address of Driver: _____

_____

Name\address of Owner: _____

_____

Vehicle: Year: _____ Make: _____ Model: _____
Color: _____ Registration: _____

Insurer and policy No.:

_____

UM? □ Yes □ No, If Yes, how much $_____

Med Pay? □ Yes □ No, If Yes, how much $_____

Does Client Own the Car: □ Yes □ No Rent: □ Yes □ No Lease: □ Yes □ No

Does client live in a household with a family member who owned and insured a car on the date of accident: □ Yes □ No If yes, please list:_____

Does client have collision insurance: □ Yes □ No

Is client filing a property damage claim: □ Yes □ No

If yes, against which company: _____

Date of Incident: _____ Day: _____ Time: _____

Seatbelt: □ Yes □ No Airbag deployed: □ Yes □ No Wipers: □ Yes □ No Lights: □ Yes □ No

Location: _____ Town/city: _____

Name of Officer and Agency that responded if any:
_____

Citations Issued: □ Yes □ No

If Yes, to Who and Why:_____

Damage to car: _____

Repaired: □ Yes □ No Estimate: □ Yes □ No Broken glass: □ Yes □ No
Car towed: □ Yes □ No Photos: □ Yes □ No

What happened (in as much detail as possible):_____

_____

_____

_____

Name/address/telephone of Occupants in Client's Vehicle:

_____

_____

_____

Name/address/telephone of Witnesses:

_____

_____

_____

Defendant's Information

Name\address of Driver:

_____

_____

Name\address of Owner:

_____

_____

Vehicle: Year: _____ Make: _____ Model: _____

Color: _____ Registration: _____

Insurer and Policy No.: _____

Does Defendant own the car: □ Yes □ No □ Not Sure: Rent: _____

Does Defendant live in a household with a family member who owned and insured a car on the date of accident: □ Yes □ No

Damage to car: _____ Repaired: □ Yes □ No
Estimate: □ Yes □ No Broken glass: □ Yes □ No Car towed: □ Yes □ No
Photos: □ Yes □ No

Medical Information

Ambulance on scene: □ Yes □ No What company?:

_____

At the time of the accident, was there any blood: □ Yes □ No

What parts of client's body are injured:

_____

When did client first go to hospital:

_____

What hospital:

_____

How did s/he get there:

_____

What was done: examination: □ x-rays: □ other:

_____

Other doctors visited, the addresses and dates:

_____

_____

_____

Medical payments (physicians, medications, health care providers, special equipment, etc.):

_____

_____

_____

Lost wages: _____

Time out: _____

Other loss:

_____

Ways pain limits activities:

_____

_____

Other symptoms: (irritability, nausea, headache, stress, inability to move body parts, insomnia, etc.):

_____

_____

_____

Physical condition prior to accident:

_____

_____

Prior physical problems:

_____

Family physician/health care provider (name, address, telephone number):

_____

Additional Information

Is client on: □ Medicare □ Medicade □ Worker's Compensation □ Social Security □ Disability Insurance

Please note, these agencies place liens on your file which may make your case more difficult to settle and which will have to be repaid.

Previous claims/lawsuits/auto-accidents/injuries/worker's comp claims: □ Yes □ No

If yes, explain:

_____

_____

Draw diagram of accident: