Information Form
Personal Injury

1. Personal and Family History

Full Name: _____

Home address: _____

Business address:

_____

Home phone: _____ Business phone: _____

E-Mail: _____

** AUTO POLICY OF CLIENT: _____
** AUTO POLICY ON VEHICLE: _____
** OTHER AUTO POLICIES OF RESIDENT FAMILY MEMBERS:

_____
_____
_____
HEALTH INSURANCE: _____
DRIVER'S LICENSE NUMBER: _____

2. Injury or Accident

Date of Incident: _____
Location of Accident:

_____

_____

Names and addresses (if known) of other people involved:

_____

_____

_____

**Insurance Co. Info of Defendant Vehicle: _____

**Insurance Co. Info of Defendant Personally: _____

Brief Description of how it happened:

(use additional sheet if necessary)

_____

_____

_____

_____

_____

_____

_____

_____

3. **Prior Claims and Lawsuits**

(*Our adversaries will inquire about your history of legal claims and lawsuits. It is important that you disclose your complete history to us. It is not fatal if you have been involved in prior legal actions. You won't be penalized by a court or jury if the claims were reasonable and genuine.*)

List every claim you have ever made for personal injury or property damage. Give details. (Attach additional page if necessary.)

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

4. **Police Record**

(*The defense will investigate your background. We must be prepared against any unfavorable evidence that is uncovered. Evidence of prior criminal acts might be used against you at trial, no matter how mitigating the circumstances.*)

List all prior arrest information:

Date Place Charge Result

_____

_____

_____

5. **Workers' Compensation**

Have you ever made a claim for workers' compensation? _____
What was your injury? _____ Date of injury: _____
Are you presently receiving payments? Yes No (Circle One) If yes, explain:
_____
Who is handling your workers' compensation action? _____
Are you receiving disability payments from sources other than worker's compensation?
Yes No (Circle One) If yes, explain: _____

6. **Prior Physical Conditions**
List every physical examination you ever had during the last 10 years for any purpose, including employment, promotion, insurance, selective service, and armed forces. (Attach additional page if necessary.)

Date: _____ Place: _____
Name of Doctor: _____
Purpose: _____ Result: _____

Date: _____ Place: _____
Name of Doctor: _____
Purpose: _____ Result: _____

Date: _____ Place: _____
Name of Doctor: _____
Purpose: _____ Result: _____

Date: _____ Place: _____
Name of Doctor: _____
Purpose: _____ Result: _____

Date: _____ Place: _____
Name of Doctor: _____
Purpose: _____ Result: _____

7. **Prior Accidents and Injuries**
(*Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem.*)

List all prior accidents, whether they resulted in a claim for damages or not.

Date	Place	Nature of Accident	Extent of injuries

8. **Illness or Disease**

(*We must know about all prior illnesses, either before or since your accident. This is particularly true if there is any connection with your present physical complaints. The defendant will have access to a complete history of your past physical condition as well as your veteran's records, insurance records, and medical/hospital records.*)

Date: _____ Nature of Illness: _____
Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
Name/address of hospital: _____

Date: _____ Nature of Illness: _____
Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
Name/address of hospital: _____

Date: _____ Nature of Illness: _____
Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
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Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
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Date: _____ Nature of Illness: _____
Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
Name/address of hospital: _____

Have you ever had trouble with your eyes? _____ Ears? _____
Please check all that apply:
Glasses/contacts: _____ Artificial eye: _____ Hearing aid: _____
Have you ever worn a brace or back and neck support? _____
Have you ever worked with radioactive substances, asbestos, or any other substance alleged to cause diseases, such as cancer? _____
Have you ever been denied health or life insurance? _____ If so, by which company? Give details: _____
_____

Have you ever been treated for alcoholism, drug addition or venereal disease?

_____

9. The Injury

State all injuries known to be a result of the accident:

_____

_____

Length of time confined to bed: _____

Length of time confined to house: _____

State present physical conditions, including scars, disabilities, deformities and discomforts due to the injuries: _____

_____

_____

_____

10. Physicians, Surgeons, Hospitals, Clinics, Therapists – ANY AND ALL health care providers you've seen related to THIS claim.
(attach additional page if necessary):

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

11. Why are you seeking the help of an attorney? In other words, what is it that you believe you are entitled to but are not receiving?
(attach additional page if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____