Portland State UNIVERSITY

PSU ID: _____

Student Legal Services
Personal Injury Client Intake Form

Smith Student Union Suite M343
1825 SW Broadway
Portland, Oregon 97207

Please fill out this form as COMPLETELY AS POSSIBLE.

Today's Date: _____ Date of Accident: _____

Conducted by: _____ Statute Runs: _____

CLIENT INFORMATION:

Last Name: _____ First Name: _____ MI ____

Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

Email Address: _____ Social Security # **BRING TO APPOINTMENT**

Drivers License #: _____ State Issued: _____

Place of Birth: _____ Spouse/partner Name: _____

INCIDENT INFORMATION

Date of Incident: _____ Day of Week: _____ Time: _____

Weather: _____ Road conditions: _____

City: _____ County: _____

Location: _____

Description of Collision or Incident: _____

_____

_____

_____

_____

_____

_____

Skid marks: _____

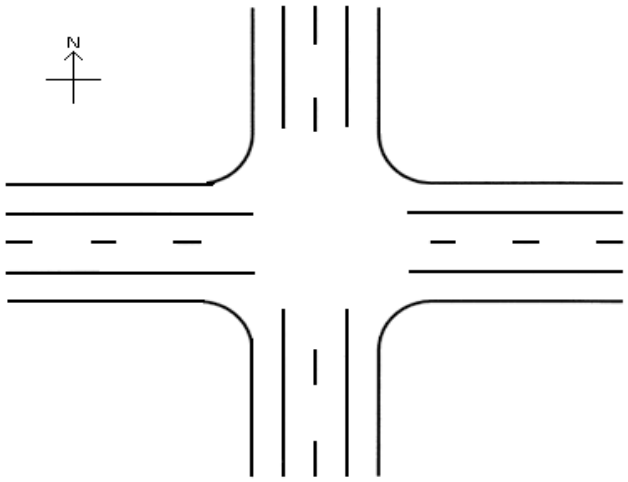
Location of debris: _____

Position of body at time of impact: _____

Your Direction of Travel: _____ Approximate Speed: _____

Lane you were in: _____

Diagram Of The Accident: (Label your vehicle with a "1" and Defendant's vehicle with a "2")



Where were you coming from / going to: _____

_____

Where was the other driver coming from / going to? _____

_____

Identity and position of all passengers in your vehicle: _____

_____

_____

Identity and position of all passengers in other vehicle: _____

_____

_____

Describe course of travel of all vehicles after impact: _____

_____

_____

Describe all conversations or discussions at scene of the accident: _____

_____

_____

Evidence of drinking, medications or drugs: _____

Means by which you left the accident scene: _____

_____

Did Police Respond? Write Yes or No _____ Was is: State, County or City_____

If City, what City:_____

Tickets issued: Write Yes or No _____ To Whom: _____

Violation(s) cited for? _____

Present Location of Plaintiff's vehicle or other evidence: _____

_____

_____

Present Location of other vehicle or evidence: _____

_____

_____

Statements given to anyone? (Including police/own insurance/other company/defendant). List date and to whom _____

_____

_____

_____

WITNESSES: All known witnesses (including police)

Name Address Phone

_____

_____

_____

_____

_____

VEHICLES:

Your Vehicle: Make_____ Model_____ Year_____ Miles _____

Color_____ License_____ Description of Damage_____

_____

_____

Other Vehicle: Make_____ Model_____ Year_____ Miles _____

Color_____ License_____ Description of Damage_____

_____

_____

PHOTOS AND OTHER EVIDENCE: Listing of all photographs taken to date:

Vehicles: _____

Accident Scene: _____

Injuries: _____

Other: _____

_____

☐ **Digital Photos** ☐ **Print Photos**

Check off all other items of evidence in your possession:

☐ Police Report ☐ DMV Report ☐ Vehicle Repair Estimate

☐ Receipt for Vehicle Repairs

INJURIES

Injuries sustained:

_____

_____

_____

_____

_____

_____

_____

_____

_____

What are your PRESENT complaints and symptoms: _____

_____

_____

_____

Have you had any similar previous illnesses or injuries? Write Yes or No _____

If yes, please describe: _____

_____

_____

_____

Have you fully recovered? Write Yes or No _____

Does your physician predict a complete recovery? Write Yes or No _____

Doctor's Advice re Injuries: _____

_____

_____

_____

What drugs or other medications have been prescribed: _____

_____

_____

Are there any activities you could perform before the crash that you cannot perform now?

_____

_____

_____

Have you had to hire domestic or child care help because of this accident? Write Yes or No _____

If yes, please describe: _____

_____

It is EXTREMELY IMPORTANT to your case that you provide a complete list of medical providers that have provided treatment for conditions arising from this accident. Be sure to include: ambulance, radiology, hospitals, primary care providers, urgent care, physical therapists, chiropractors, homeopaths, massage therapists, surgeons, anesthesiologists, specialists, psychologists and dentists. It is your responsibility to provide my office with any additional providers that you may seek treatment with after completing this list.

1. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

2. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

3. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

4. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

5. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

6. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

7. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

8. Provider's Name: _____ Specialty: _____
   Address: _____
   Phone: _____ First Visit: _____ Still treating? Write Yes or No _____

****Please list any additional providers on the back of this page along with any questions you may have regarding your case. Thanks.**

Have you received any offers from any insurance companies?: Write Yes or No _____

If 'yes', please advise: When?: _____ Amount/how much?: _____

CLIENT'S INSURANCE:

Client's **AUTO** insurance carrier: _____

Agent: _____

Policy # _____ Claim # _____

Claims Adjuster _____ Phone _____

Address _____

Limits on PIP _____ Limits on Liability _____

Limits on UM/UIM _____ Collision coverage/deductible _____

Company Notified? (When/ By whom:) _____

Statement Given? (When / To Whom) _____

Releases Signed? (When / To Whom) _____

Do you have an **umbrella** policy? Write Yes or No _____ -- If Yes, Limits: _____

Client's **HEALTH** Insurance Provider: _____

Address: _____

Phone: _____ Policy/Group #: _____

AT-FAULT PARTY ("BAD GUY") INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone_____ Employment (if known) _____

Drivers License #_____ State Issued: _____ DOB: _____

Owner of Vehicle (if different than driver) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone_____ Employment (if known) _____

Drivers License #_____ State Issued: _____

At-Fault Party **AUTO** Insurer: _____

Agent: _____ Address: _____

City: _____ State: _____ Company Notified?: Write Yes or No _____

Adjuster Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____

Policy # _____ Claim # _____

YOUR BACKGROUND INFORMATION:

Educational History: _____

Occupational/Employment History: _____

_____

_____

Have you ever filed for bankruptcy? Write Yes or No _____ If yes, when? _____ What chapter? _____

Do you have any prior criminal convictions? [ ] Yes [ ] No If yes, what convictions and when?

_____

_____

Have you ever been involved in any type of civil lawsuit? Write Yes or No _____

If yes, please describe it, including the nature of the case and the date: _____

_____

Name & number of friend/relative not living with you: _____

Height _____ Weight _____

Currently receiving any Public Assistance / Type? _____

Children or other persons living in household:

Name	Age	Living at Home?

YOUR EMPLOYMENT INFORMATION:

Employer: _____ Occupation:_____

Work Address: _____

Daily Work Activities: _____

_____

_____

Date Employment Commenced: _____

Weekly/Biweekly/Monthly/Annual Salary: _____ Hourly Wage: _____

No. of Hours Worked Per Day: _____ No. of Days Worked Per Week: _____

Supervisor: _____ Phone No.: _____

Estimated Value of Lost Wages: $_____ Last Day Worked Before Accident: _____

Date Returned to Full Time/Full Capacity: _____

Were you on Light/Restricted Duty? _____ How Long? _____

Will your injuries prevent you from working to your full capacity in the future? Write Yes or No _____

How so? _____

_____

_____

_____

PRIOR INJURIES:

Have you ever filed a Worker's Compensation Claim? Write Yes or No _____

If yes, please describe what happened: _____

_____

Injuries and treatment: _____

_____

Date of Incident: _____ Claim No.: _____

Worker's Compensation Carrier: _____

Have you ever been in an auto accident prior to this: Write Yes or No _____

If yes, please describe what happened: _____

_____

Injuries and treatment: _____

_____

Date of Incident: _____ Claim No.: _____

Your Auto Insurance Carrier at that time: _____

Was there a lawsuit? Write Yes or No _____

Was there a settlement? Write Yes or No _____

If yes, were you awarded money? Write Yes or No _____

Medical Information:

History of all prior injuries or hospitalizations, including dates: _____

_____

_____

_____

_____

_____

_____

Did you have any physical complaints BEFORE THE ACCIDENT? Write Yes or No _____

If yes, please describe in detail: _____

_____

_____

_____

_____

Additional Comments: