INITIAL CLIENT INTERVIEW
Tourkow Crell Rosenblatt & Johnston LLP

Date of Intake Meeting: _____ Date of Accident: _____

Statute of Limitations: _____

PERSONAL

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____

Social Security Number: _____

Marital Status: _____ If Married, Spouse's Name: _____

Alternate Contact (Name and Phone No.): _____

EMPLOYMENT

Name of Employer: _____

Work Phone: _____

Job Title: _____ Salary/Wage Rate: _____

Length of Time with Employer: _____

Full or Part Time: _____

Time Lost: _____

INSURANCE COVERAGE

Client – Health Insurance:

Name of Company: _____

Client – Auto Insurance:

Name of Company: _____

Policyholder: _____

Address of Insurer: _____

Phone Number of Insurer: _____

Fax Number of Insurer: _____

Claim No.: _____

Adjuster's Name: _____

Was it reported? _____ Recorded Statement? _____

Other Driver:

Name: _____

Name of Insurance Company: _____

Policyholder: _____

Address of Insurer: _____

Phone Number of Insurer: _____

Fax Number of Insurer: _____

Claim No.: _____

Adjuster's Name: _____

Amount of BI: _____

Was it reported? _____ Recorded Statement? _____

ACCIDENT DETAILS

Date of Accident: _____ Time of Accident: _____

Type of Accident: _____

Place of Accident: _____

Were you the driver/passenger/pedestrian in accident? _____

How many vehicles involved in the accident? _____

How many lanes in each direction? _____

What lane were you traveling in? _____

What was your planned destination? _____

Description of Accident: _____

_____

_____

_____

What parts of vehicle made impact? _____

Describe the impact: _____

_____

_____

Notes regarding initial impact: _____

_____

_____

Weather Conditions: _____

Seatbelts on? _____

Did the airbags deploy? _____

Were you on the cell phone at the time of the accident? _____

Do you know if the other driver was on the cell phone at the time of the accident? _____

Were police called to the scene? _____

Was there anyone else in the vehicles? If so, please provide names and addresses: _____

_____

_____

PROPERTY DAMAGE

Vehicle Make and Model: _____

Year: _____ Color: _____ Owner: _____

Describe All Damage to the Vehicle: _____

_____

Damage to inside of vehicle? _____ If so, describe damage: _____

_____

_____

Is your vehicle drivable? _____

Amount of Damage: _____

Who appraised and repaired vehicle: _____

Photos taken? _____

MEDICAL

Treating Physician: _____

Address: _____

Phone No.: _____

Treating Physician: _____

Address: _____

Phone No.: _____

Treating Physician: _____

Address: _____

Phone No.: _____

Treating Physician: _____

Address: _____

Phone No.: _____

Miscellaneous Facilities (Hospital, Ambulance, etc.): _____

_____

_____

Injuries – Complaints/Diagnosis: _____

_____

_____

MEDICAL HISTORY – PRIOR ACCIDENTS

Prior Medical Conditions: _____

Medications Taken on Regular Basis and Reason for Taking Said Medications: _____

_____

Prior Auto Accidents: _____

Prior Auto Accident Claims and Injuries: _____

_____

Slip and Falls: _____

Worker's Compensation: _____

Prior Fractures/Major Hospitalizations/Surgeries: _____

Prior Treatment with Chiropractor: _____