PERSONAL INJURY INTAKE SHEET

PERSONAL INFORMATION

Client's Name _____

Aliases _____

Date _____

Address _____

Phone H _____ W _____

SSN _____ Race _____ Sex _____

Age _____ DOB _____

Marital Status ☐ M ☐ S ☐ D

Resides With _____

List addresses where client has resided during the past 10 years and period of time at each residence

Address	From	To

EDUCATION

Educational background, listing names of schools attended, addresses, years attended and any degrees obtained

Name & address of school	Years attended	Degree

CHILDREN

Child(ren) Name(s)	Age	Date of Birth

Father's Name _____

Address _____

Phone H _____ W _____

Employer _____ Position Held _____

Employer's Address

Mother's Name _____
Address _____
Phone H _____ W _____
Employer _____ Position Held _____
Employer's Address _____

If client is acting on behalf of a deceased relative, list the names, addresses, telephone numbers and relationships to decedent of the decedent's immediate family

Name _____
Address _____
Telephone _____
Relation _____

Name _____
Address _____
Telephone _____
Relation _____

Name _____
Address _____
Telephone _____
Relation _____

Name _____
Address _____
Telephone _____
Relation _____

Spouse's Name _____
Is your spouse employed? ☐ Yes ☐ No If so, indicate
Employer's name _____ Telephone _____
Address of spouse's employer _____
Present rate of pay $ _____ per ☐ week ☐ month ☐ year
Average yearly income of spouse $ _____ How long with this employer?
List spouse's employment history for past five years
Name of employer _____
Address _____
Period of employment From _____ To _____
Position _____ Salary $ _____
Reason for leaving _____

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving _____

EMPLOYMENT INFORMATION

Name of employer (if unemployed, last employer) _____

Address of employer _____

Telephone number _____

Personnel Director/Supervisor _____

Job title/type of work _____

Present rate of pay $ _____ Per ☐ Week ☐ Month ☐ Year

Hours worked each week _____ Do you regularly work overtime? ☐ Yes ☐ No

If so, indicate approximate amount of time & rate of pay Hours _____ Rate of Pay _____

Do you receive tips or other type of income? ☐ Yes ☐ No If so, indicate

Type of income	Amount	Per week/month/year
_____	$ _____	_____
_____	$ _____	_____

_____ _____ _____

_____ $ _____ _____

_____ $ _____ _____

When did you first begin working for this employer? _____

If unemployed, when did you leave this employer? _____

Reason for leaving _____

What was your reported income in the year before your accident? $ _____

Were you working for your employer at the time the injury occurred? ☐ Yes ☐ No

Did you applied for worker's compensation benefits because of your accident? ☐ Yes ☐ No

If so, indicate the amounts paid to or received by you to date $ _____

State your employment history for past ten years

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving _____

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving _____

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving _____

Name of employer _____

Address _____

Period of employment From _____ To _____

Position _____ Salary $ _____

Reason for leaving _____

POLICE RECORD

Have you ever been convicted of a ☐ Yes ☐ N If so, describe as follows

felony? o

Place _____

Charge _____

Result _____

Date of conviction _____

Place _____

Charge _____

Result _____

Date of conviction _____

Place

Charge

Result

Date of conviction

Is there now, or has there ever been, a restriction on your driver's license? ☐ Yes ☐ No

If so, describe the details of such restriction _____

_____

_____

CLAIMS AND LAWSUITS

Have you ever been involved in any claim or lawsuit, excluding divorce? ☐ Yes ☐ No

If so, list below every claim you have made for money or lawsuits in which you have ever been involved

Date _____ Place _____

Against whom _____

Nature of claim _____

Result _____

Date _____

Against whom _____

Nature of claim _____

Result _____

Date _____

Against whom _____

Nature of claim _____

Result _____

INSURANCE INFORMATION

Name of insurance company _____

Address _____

Adjuster's name _____ Telephone _____

Policy number _____ Policy limits $ _____

Do you have insurance covering damage to your car? ☐ Yes ☐ No

Deductible amount $ _____

How much does your insurance cover if you hurt someone else with your car? $ _____

Uninsured motorist policy limits $ _____ Med Pay Amount $ _____

Do you have a second uninsured motorist policy? ☐ Yes ☐ No If so, fill in the following

Name of second insurance company _____

Address _____

Adjuster's name _____ Telephone _____

Policy number Policy limits $

Do you have health or accident insurance? ☐ Yes ☐ No If so, indicate

Name of health insurance company _____

Policy # _____

Address _____

Insurance agent's name _____ Telephone _____

Name of accident insurance company _____

Policy # _____

Address _____

Insurance agent's name Telephone

Have you ever had insurance of any kind declined or cancelled? ☐ Yes ☐ No

If so, give reason _____

_____

_____

MEDICAL HISTORY BEFORE ACCIDENT

Have you been hospitalized at any time before this accident? ☐ Yes ☐ No

If so, list below all hospitalizations

Date	Name of Hospital and Doctor	Duration	Nature of illness

Have you had any physical examinations before this accident? ☐ Yes ☐ No

If so, list below all physical examinations for five years before this accident

Date	Name of Doctor and Address	Purpose

Have you had any accidents or injuries before this accident? ☐ Yes ☐ No

If so, list below every such accident or injury and whether there was a claim for damages or not

Date _____ Place _____

Nature of accident/injury _____

Name of treating physician _____

Claim? ☐ Yes ☐ No

Date _____ Place _____

Nature of accident/injury _____

Name of treating physician _____

Claim? ☐ Yes ☐ No

Date _____ Place _____

Nature of accident/injury _____

Name of treating physician _____

Claim? ☐ Yes ☐ No

Have you had any chronic illnesses or diseases before this accident? ☐ Yes ☐ No

If so, list every such illness or disease suffered in the five years before this accident

Have you had any other chronic health problems or disabilities? ☐ Yes ☐ No

If so, list them below

Did you use any drugs or medication regularly before the accident? ☐ Yes ☐ No

If so, list the type of drug and reason for use

Have you ever had any broken bones? ☐ Yes ☐ No

If so, give date and circumstances

Date	Circumstances

MILITARY BACKGROUND

Were you in the military service? ☐ Yes ☐ No Branch of service

Dates from _____ to _____

Type of discharge

Any service-connected injuries? ☐ Yes ☐ No | If so, describe details

Have you received or do you receive payments from VA, social security or other source?
☐ Yes ☐ No Claim number _____

FACTS OF THE ACCIDENT

Date _____ Day _____ Time _____

Weather conditions _____

Were seat belts in use in your vehicle? ☐ Yes ☐ No

If so, who in your vehicle was using a seat belt and who was not using a seat belt?

Were police called to the scene of the accident? ☐ Yes ☐ No

If so, did the police take photographs of the accident scene? ☐ Yes ☐ No

If so, which police department has possession of such photographs? _____

Describe what happened

DIAGRAM

Indicate on a diagram in the space below what happened. Write in street or highway names or numbers and show direction of travel by arrows. Also, show north by putting an arrow in a circle

FACTS CONCERNING THE DEFENDANT - (person responsible for accident)

Full name of defendant _____

Address _____

Name of defendant's employer _____

Name of defendant's spouse _____

Name of defendant's insurance company _____

Address _____

Adjuster's name _____ Phone _____

Policy No. Claim No. Policy limits $

Do you know what the defendant's financial circumstances are, excluding any insurance coverage?

If so, specify _____

Give your observations about the defendant as a person _____

Name of 2nd person responsible for accident _____

Address _____

Name of 2nd person's insurance company _____

Address _____

Adjuster's name _____ Phone _____

Policy No. _____ Claim No. _____ Policy limits $ _____

Name of 3rd person responsible for accident _____

Address _____

Name of 3rd person's insurance company _____

Address _____

Adjuster's name _____ Phone _____

Policy No. _____ Claim No. _____ Policy limits $ _____

OTHER INJURED PARTIES

Were other parties, other than the defendant, injured in this accident? ☐ Yes ☐ No

If so, indicate the following

Name of 2nd injured party: (2nd plaintiff) _____

Address _____

Relationship to you _____ Telephone number _____ Birthdate _____

Name of 3rd injured party: (3rd plaintiff) _____

Address _____

Relationship to you _____ Telephone number _____ Birthdate _____

WITNESSES TO THE ACCIDENT

List the names, addresses, and telephone numbers of all witnesses to the accident, and any other persons who may be of assistance in testifying about your case, your injuries or changes in your activities since the accident

Name of 1st witness _____

Address _____

Telephone _____ Age _____

Employment _____

Nature of testimony _____

_____

_____

Name of 2nd witness _____
Address _____
Telephone _____ Age _____
Employment _____
Nature of testimony _____

Name of 3rd witness _____
Address _____
Telephone _____ Age _____
Employment _____
Nature of testimony _____

STATEMENTS MADE

Have you talked with any police officer, investigator, insurance adjuster or any other person about this incident? ☐ Yes ☐ No If so, indicate to whom you have spoken, the person's address and telephone number

Name	Address	Telephone

Have you given a written or recorded statement to any person about this incident?
☐ Yes ☐ No If so, answer the following
Name of person to whom statement was given _____
Date given _____ If written, do you have a copy? ☐ Yes ☐ No
Persons present at time _____

Did you sign the statement? ☐ Yes ☐ No
Did the defendant make any statement to you or in your presence concerning this incident?
☐ Yes ☐ No If so, indicate what was said and to whom _____

When and where was the above statement made?

Date _____ Place _____

List the names and addresses of any persons who may have heard it

Name	Address

Were any statements about the accident made to or taken from anyone else at the scene of the accident? ☐ Yes ☐ No

If so, describe the name of the person from whom the statement was taken, as follows

Name _____ Telephone number _____

Nature of statement _____

Were any statements about the accident made to or taken from anyone else at the scene of the accident? ☐ Yes ☐ No

If so, describe the name of the person from whom the statement was taken, as follows

Name _____ Telephone number _____

Nature of statement _____

DAMAGES FROM ACCIDENT

The amount of recovery made in this case will be affected by the injuries, damages or expenses incurred as a result of your accident. It is important that you fully list all information regarding your injuries and your expenses as a result of this accident. State in full detail all injuries you received as a result of this accident: _____

State your present physical condition such as scars, deformities, headaches, etc.

Describe "loss of enjoyment of life" by listing what normal activities, including sports, hobbies or other activities you enjoyed before this accident and cannot do now as a result of the accident

Activity	Times/week prior to accident	Times/week after accident

Have you missed time from work as a result of your injuries? ☐ Yes ☐ No

If so, indicate the following

From	To

Did you lose wages for the periods of time missed from work due to this accident?

☐ Yes ☐ No If so, state the total wages lost to date and the dates

Wages lost	Dates

Have you had any increases or decreases in your pay since the accident? ☐ Yes ☐ No

If so, explain _____

_____

Did you lose any promotion or merit increase or fringe benefits due to the accident?
☐ Yes ☐ No If so, describe _____

_____

_____

_____

_____

If self employed, have you had to hire anyone to take your place? ☐ Yes ☐ No
If so, indicate the costs involved _____

_____

_____

_____

If you are a student, indicate time lost from school

From	To

Indicate period of time you were confined to your home

From	To

Indicate period of time you were confined to bed rest

From	To

When is it expected you can return to work? _____

List any non-monetary compensation you have lost _____

_____

Have you been forced to borrow any money as a result of your injuries and inability to work?
☐ Yes ☐ No If so, describe _____

_____

_____

Are you able to work part time? ☐ Yes ☐ No
If so, where or what kind of work could you do? _____

_____

_____

List all hospitals in which you were examined or treated or to which you were admitted as a patient as a result of the injuries sustained in this accident
Name of hospital
Address
From _____ To _____
Total costs $ _____

Name of hospital
Address
From _____ To _____
Total costs $ _____

Name of hospital
Address
From _____ To _____
Total costs $ _____

List the full name, address and telephone number of each physician who has examined or treated you for your injuries
Doctor's name _____ Telephone _____
Address _____
Specialty _____
Type of treatment _____

Doctor's name _____ Telephone _____
Address _____
Specialt _____

y _____

Type of treatment _____

Doctor's name _____ Telephone _____

Address _____

Specialty _____

Type of treatment _____

Doctor's name _____ Telephone _____

Address _____

Specialty _____

Type of treatment _____

Have you used any of the following in connection with treatment?

	Dates From	To
Wheelchair		
Back or neck brace/collar		
Crutches		
Traction		
Physical therapy		
Other _____		
_____		
_____		

List all medications which you have taken for injuries, the name of the doctor prescribing each medication and length of time you took the medication

Type of medication	Prescribing doctor's name	Length of time

Indicate the amount of all bills/expenses incurred to date as a result of this accident (attach copies of

all such bills, whether paid or unpaid.) $ _____

Have you sustained any other injuries since this accident? ☐ Yes ☐ No
If so, indicate date, nature of injury and whether you received medical treatment for said injuries

Date of injury	Nature of injury	Medical treatment

PROPERTY DAMAGE

If your vehicle was damaged and has been repaired, indicate name and address of party who made repairs

Name of Person who performed repairs _____

Address _____ Telephone number _____

Have you incurred car rental expenses? ☐ Yes ☐ No Total Rental Expense $ _____

Where is your vehicle presently located? _____

If any other personal property was damaged, describe said property

_____

_____

Total medical & related expenses to date $ _____ Date _____

Total of property damage amount to date $ _____ Date _____

IMPORTANT

Please collect and attach copies of all medical and related bills incurred to date as a result of this accident, indicating which have been paid and which are still due. Please be sure to forward copies of all future medical bills, drug/medication bills, etc., As they are incurred, even if paid by insurance. See the following two pages for list of items to provide to your attorney and a list of general instructions that will require your attention. In completing this intake sheet, have you thought of any information which I have not asked which may be of some assistance to me in representing you? If so, state it on the back of this form no matter how silly, trivial or embarrassing it may seem.

_____
Client's signature

_____
Date

INSTRUCTIONS TO CLIENT

Please be sure to provide me with the following

1. All medical and hospital records
2. Photographs (of scene of accident, of client showing injuries, braces, casts, etc., of automobile or other damaged property)
3. All hospital, medical and related bills, either paid or unpaid (physicians, surgeons, ambulance, hospitals, private nursing care, therapy, drugs/medication, crutches, braces, x-rays, domestic help, car rental, clothing, etc.)
4. Income tax returns for the last five years
5. Your automobile insurance policy or policies
6. Insurance policy that may require aid of attorney to notify and collect (income protection, hospitalization, etc.)
7. Copies of any statements previously made to anyone (opposing side, your insurance carrier, etc.)
8. Repair bill on any damaged property
9. Repair estimates on any damaged property
10. Purchase invoices and estimates of value of personal property damaged or lost in accident (including clothing, jewelry, cameras, and all other property damaged in accident)
11. Correspondence with insurance company, insurance adjusters
12. Business cards from insurance company agents and adjusters, opposing driver, etc.
13. Copy of any accident reports
14. Statement from employer regarding lost wages showing time and wages lost from work
15. Copies of check stubs and/or other records showing hourly rate of pay
16. Copies of any application for other insurance benefits
17. Copy of any application for unemployment benefits
18. Copy of social security card

19 Make copy of current driver's license
.

Please note the following general instructions

1. Do not talk to insurance adjuster
2. Do not discuss the facts of the accident with anyone before having your first conference with the attorney
3. Do not sign anything without your attorney's permission
4. Keep a diary of your trips to all doctors, hospitals, therapists and notes of your pain with times and dates
5. Keep all your medicine bottles and containers (as possible evidence at trial)
6. Bring or send all future medical bills to attorney's office
7. When you return to treating physicians for follow- up examinations, be sure to advise them at each examination the nature of all of your continuing problems resulting from the accident
8. Keep a record of all out-of-pocket expenses, including travel expenses for medical treatment
9. Report to your attorney any suspicious actions, such as someone taking pictures, movies, etc.

EMPLOYMENT CONTRACT AND POWER OF ATTORNEY
IN A PERSONAL INJURY CASE

THIS AGREEMENT made this date at _____, _____, by and between _____, Attorney at Law, hereinafter known as ATTORNEY and _____ hereinafter known as CLIENT.

WITNESSETH:

1. CLIENT retains ATTORNEY to represent him as his Attorney at Law in a cause of action against _____ regarding the following facts, to-wit:

_____

_____

_____

This contract empowers ATTORNEY to institute such legal action as may be advisable in his judgment and to compromise and settle the matter at any time, with the consent of the CLIENT, and CLIENT agrees to pay ATTORNEY for his services, **_____ percent (____%)** of the amount recovered if settled without suit, or, **_____ (____%)** of the amount recovered after suit is instituted by filing the first paper therein for litigation through Circuit, Chancery, or Federal Court. In the event of an appeal to the State Supreme Court or the Federal Appellate Courts, ATTORNEY shall be further entitled to all penalties assessed against the Defendant, as his fee. All costs and expenses advanced by the ATTORNEY shall be deducted from the CLIENT'S share.

2. CLIENT hereby assigns and gives ATTORNEY a lien on said claim, cause of action, and/or any sum recovered by way of settlement or judgment thereon for the sum and share hereinabove mentioned as his fee. CLIENT hereby agrees that said Attorney's lien shall attach in full (in the percentages set out in paragraph one (1) to any offer of settlement extended in this matter while ATTORNEY is employed.

3. CLIENT agrees that if this employment agreement is terminated by CLIENT for any reasons after employment begins but prior to a settlement offer being extended, that ATTORNEY is entitled to be paid for his time expended to the date of termination at a liquidated rate of _____ dollars ($_____) per hour, plus reimbursement of all advanced cost and expenses. CLIENT agrees to pay said fees, cost and expenses prior to his file being returned to him, unless retaining said file prejudices the rights of the CLIENT.

4. CLIENT hereby agrees that if he elects to employ other counsel that said counsel shall be paid out of CLIENT'S share. ATTORNEY agrees to pay any counsel associated by ATTORNEY out of ATTORNEY'S share.

5. CLIENT hereby gives ATTORNEY his **POWER OF ATTORNEY** to execute all complaints, claims, contracts, checks, settlements, drafts, compromises, releases, verifications,

dismissals, deposits and orders as he would himself. CLIENT agrees that he will make no settlement except in the presence of his ATTORNEY or with his knowledge and approval, and should he do so in violation of this agreement, he agrees to pay ATTORNEY the sum and share indicated in paragraph one (1) of this agreement.

6. The ATTORNEY hereby accepts employment in the above particulars and agrees to represent the CLIENT to the best of his ability and with all fidelity.

7. It is mutually understood that the masculine shall include the feminine and the neuter, and the singular shall include the plural, wherever used hereinabove.

IN WITNESS WHEREOF, the parties have set their hands this the _____ day of _____, 20_____.

ATTORNEY: CLIENT(S):

BY: _____
_____

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned _____, hereby authorize any physician, hospital, nurse, chiropractor, dentist, psychologist, or other medical attendant to furnish full and complete medical reports, records, and other information herewith requested by _____, Attorney at Law, or to any representative, attorney or investigator from his firm.

The purpose of this authorization is to allow the above attorney to obtain all medical records which will aid in or are necessary for the prosecution of claims I am making.

This authorization includes the right to examine all x-rays and records of any kind, and the right to receive full and complete information pertaining thereto, including copies of all such records.

This authorization is intended to and will allow the above attorney to obtain any and all medical records, and shall include any and all records prior to or subsequent to the date of the claim referred to above.

In addition, it is expected that I may need further treatment beyond the date of this authorization, and you are therefore authorized and requested to provide to the above attorney any and all medical records related to examinations and treatment which take place subsequent to the date of the execution of this authorization, so long as this authorization has not been cancelled or revoked by me in writing.

Your full cooperation with my attorney is requested. <u>You are further requested to disclose no information nor discuss my medical condition with any insurance adjuster or other person without my written authority to do so.</u>

This authority shall be valid until cancelled or revoked by me in writing.

A photostatic copy of this authorization shall be considered as effective and as valid as the original

ALL PRIOR AUTHORIZATION IS HEREBY CANCELLED

_____ _____

DATE PATIENT

FORM 4506 REQUEST FOR COPY OF TAX FORM OR INDIVIDUAL INCOME TAX ACCOUNT INFORMATION (OMB Clearance Number 1545-0429)

1. Name of taxpayer as shown on tax form _____
2. Current name and address _____

_____

3. If information is to be mailed to someone else, show the third party's name and address
   Name _____
   Address _____
4. If name in third party's records differs from item 1 above, show here (see instructions for item 3) _____
5. Social security or employer identification number as shown on tax form _____
6. Spouse's social security number as shown on tax form
   Spouse's name _____
   Spouse's SS no _____
7. Tax form number (Form 1041, 941, etc.) _____
8. Tax period(s) (No more than 4 per request) _____
9. Amount due (Make check payable to IRS) $ _____
   Note: Full payment must accompany your request
10. Describe what you want (Check only one box)

$5.00 each	☐	Copy of tax return and all attachments (including forms w-2)
	☐	Note: if you need these copies certified for court or administrative proceedings, check here also
$2.50 each	☐	Tax account information only (do not use for income averaging)
$2.50 each	☐	Form 1040a or form 1040ez verification only

PRIVACY ACT AND PAPERWORK REDUCTION ACT NOTICE

We ask for this information to carry out the Internal Revenue laws of the United States. We need the information to gain access to your return in our files and properly respond to your request. If you do not furnish the information, we may not be able to fill your request.

DATE _____ Signature _____

Telephone _____

Out of Pocket Expenses

Client _____

DOCTOR BILLS

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL DOCTOR BILLS $ _____

DRUGS

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL DRUG BILLS $ _____

HOSPITAL

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL HOSPITAL BILLS $ _____

PROPERTY DAMAGE

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL PROPERTY LOSS $

EARNINGS LOSS

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL EARNINGS LOSS $ _____

OTHER LOSS

_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL OTHER LOSS $ _____

TOTAL OUT OF POCKET LOSS $ _____