PREMISES LIABILITY ACCIDENT
PERSONAL INJURY CLIENT QUESTIONNAIRE

Person Filling Out This Report _____ Date _____

Instructions: Please fill out the following questionnaire as best you can. I know that there are many requests for information that you may not have or that may not be applicable to your case. If such is the case, simply skip those questions. However, the more information you provide me with the better job that I can do for you on your case. Therefore, the more you put into filling out this questionnaire, the better chance you will have of being successful with your case.

PERSONAL INFORMATION

Name _____
Address _____
Telephone No.'s (home) _____ (work) _____ (other) _____
Social Security Number _____ Date of Birth _____
Height _____ Weight _____ Age _____ Race _____

Marital Status

Name of Spouse, if any _____
Social Security Number _____ Age _____

Children

Name	Age

PREMISES INFORMATION

Name of Establishment _____

Address _____

Manager _____

Employees Having Knowledge About Incident

Name _____

Address _____

Phone number _____

Name _____

Address _____

Phone number _____

Name _____

Address _____

Phone number _____

Name _____

Address _____

Phone number _____

Property and Casualty Insurer

Name of Insurer _____

Insurer's Address _____

Policy Number _____ Limits of Coverage $ _____

Adjustor _____

Insurer's Phone Numbers _____

Settlement Offers $ _____

Claim Number _____

INCIDENT

Date of Incident _____ Time of Incident _____

Location of Incident _____

Description of Scene _____

Weather Conditions at Time of Incident _____

Drugs or Alcohol Involved ☐ Yes ☐ No

Pictures of Scene ☐ Yes ☐ No

Please Describe in Detail What Happened

WITNESSES

Name _____

Address _____

Telephone Numbers (home) _____ (work) _____ (other) _____

Statements _____

Description of Witness _____

Relationship to Client _____

Other Information about Witness _____

Name _____
Address _____
Telephone Numbers (home) _____ (work) _____ (other _____)

Statements _____

Description of Witness _____

Relationship to Client _____

Other Information about Witness _____

Name _____
Address _____
Telephone Numbers (home) _____ (work) _____ (other _____

_____ _____ _____
_____ _____)

Statements _____

Description of Witness _____

Relationship to Client _____

Other Information about Witness _____

OTHER WITNESSES (Please give as much information about these people as possible)

INJURIES

Description of Injuries _____

Pictures of Injuries ☐ Yes ☐ No

Preexisting Injuries _____

MEDICAL TREATMENT

Physicians

Name _____

Medical Group _____

Address _____

Telephone Numbers _____

Dates of Treatment _____

Description of Treatment _____

Diagnosis _____

Prognosis _____

Medications _____

Records _____

Amount of Bills $ _____

If Released from Care, When _____ Why _____

Name _____

Medical Group _____

Address _____

Telephone Numbers _____

Dates of Treatment _____

Description of Treatment _____

Diagnosis _____

Prognosis _____

Medications _____

Records _____

Amount of Bills $ _____

If Released from Care, When _____ Why _____

Name _____
Medical Group _____
Address _____
Telephone Numbers _____
Dates of Treatment _____

Description of Treatment _____

Diagnosis _____

Prognosis _____

Medications _____

Records _____

Amount of Bills $ _____

If Released from Care, When _____ Why _____

Hospitals

Name _____
Address _____
Telephone Numbers _____

Records _____

Amount of Bills $ _____

Name _____
Address _____
Telephone Numbers _____

Records _____

Amount of Bills $ _____

Physical Therapist

Name _____
Address _____
Telephone Numbers _____

Records _____

Amount of Bills $ _____

SUBROGATION LIENS

Name of Lienholder _____
Amount of Lien $ _____

Nature of Lien _____

Name of Lienholder _____
Amount of Lien $ _____
Nature of Lien

EMPLOYMENT

Employers' Names _____
Addresses _____
Telephone Numbers _____
Name and Job Title of Immediate Supervisor _____
Rate of Pay $ _____ per _____
Time Missed from Work Due to Injury _____
Lost Wages $ _____
Date Returned to Work _____
Have You Filed Tax Returns for the Past Two Years ☐ Yes ☐ No

HEALTH INSURANCE

Name of Your Health Insurance Company _____
Address _____
Amount of Deductible or Co-pay $ _____
Amounts Paid by Health Insurance to Date $ _____
Amounts Paid by You to Date $
Names of Adjustors if Known _____
Telephone Number of Health Insurance Company

OTHER INFORMATION

Prior Lawsuits:(give date, injuries, circumstances, and resolution)

Prior Convictions (give dates, sentence, and current status)

Drinking Habits

Smoking Habits

Settlement Offers

Referred By _____

Other Attorneys Consulted ☐ Yes ☐ No Name _____

Miscellaneous _____

CLIENT COMMENTS

DOCUMENTS NEEDED

I need the originals of the following documents if you have them. Please include these documents when you return this questionnaire if you have them. If you do not have them, you are in the process of getting them, or they are not available yet, please state where they are, when they will be ready, and how I can get them. Have you provided the following?

Incident or accident report ☐ Yes ☐ No

All of your medical records ☐ Yes ☐ No (If you are still being treated, please describe what you have provided, and when you anticipate being released from treatment.)

All of your medical bills ☐ Yes ☐ No (If you are still being treated, please describe what you have provided, and when you anticipate being released from treatment.)

Recent payment stubs ☐ Yes ☐ No

The past four years Income Tax Returns ☐ Yes ☐ No

The past four years W-2's ☐ Yes ☐ No

Pictures of your injuries ☐ Yes ☐ No

Pictures of the scene of the accident if you have any ☐ Yes ☐ No

Letters from insurance companies regarding this matter ☐ Yes ☐ No

Any other documents or other materials ☐ Yes ☐ No
(Please describe any other documents or other materials which you have either provided or which you believe exist and may be helpful to your case. Also, explain how you believe this document or other material may be helpful to your case. Other materials may include pictures or pieces of physical evidence which tend to show either liability or your damages.)

CLIENT EXPECTATIONS

Describe your expectations for the outcome of your case

How much money do you expect to recover after payment of legal fees? $ _____

Please describe all circumstances which you believe support your recovery of this amount

EVALUATION
(For Attorney's Use Only)

Total Medical Bills $ _____

Extent of Injuries _____

Liability _____

Available Insurance Coverage _____

Valuation $ _____

Type of Representation and Attorney Compensation _____

Comments _____