Claim of Negligence Questionnaire

Client name: Address:
Home phone: Work phone: Cell phone:
Birth date: Social Security Number:
Drivers License Number: State:

THE ACCIDENT

Date of accident: Time: Location:
Owner of property at accident location:
Name: Address:
Home phone: Work phone: Cell phone:
What were the weather conditions at the time of the accident?
Describe how the accident happened:
What were you doing immediately prior to the accident?
What do you think could have been done to prevent the accident?
Do you think anything could have been done to make the accident less serious? Yes ☐ No ☐ If yes ,please describe:
Are you aware of any previous complaints about the situation/location? Yes ☐ No ☐
If yes ,please describe:

RESPONSE TO ACCIDENT

Did you make any oral or written statements at the scene of the accident? Yes ☐ No ☐
If yes ,please describe statement and to whom:
Did you read and sign the statement? Yes ☐ No ☐
Do you have a copy of the statement? Yes ☐ No ☐
Did you make any oral or written statements after the accident, such as to an insurance adjuster? Yes ☐ No ☐ If yes ,please describe statement and to whom:
Did you read and sign the statement? Yes ☐ No ☐
Do you have a copy of the statement? Yes ☐ No ☐
Did the police come to the scene of the accident? Yes ☐ No ☐
Do you have a copy of the police report? Yes ☐ No ☐
Were any citations issued or arrests made? Yes ☐ No ☐
Did anyone take pictures of the accident scene? Yes ☐ No ☐
Did anyone take pictures of your injuries? Yes ☐ No ☐
Do you believe alcohol/drugs/medication was a factor in causing the accident? Yes ☐ No ☐ If yes, why?
Witness information: Name: Address: Home phone: Work phone: Cell phone:

Name: Address: Home phone: Work phone: Cell phone:

Name: Address: Home phone: Work phone: Cell phone:

Name: Address: Home phone: Work phone: Cell phone:

INJURIES

Were you injured in the accident? Yes ☐ No ☐
Were you taken to the hospital? Yes ☐ No ☐
If yes, name of hospital: If yes, name of doctor:
If by ambulance, did the ambulance attendants place you in a ☐ neck brace ☐ back brace ☐ other
Did you get any medication or medical supplies? Yes ☐ No ☐ If yes, describe:
Did you have x-rays taken at the hospital? Yes ☐ No ☐
What medical treatment have you received?
How often did you see the doctor?
How long did you see the doctor?
Next visit scheduled: Diagnosis:
Have you had any similar problems before? Yes ☐ No ☐ If yes, explain:
Have you ever been rejected for military service because of physical, mental, or other reasons? Yes ☐ No ☐ If yes, explain:
Do you wear glasses, contact lenses, or any prosthetic devices? Yes ☐ No ☐ If yes, explain:
Is there any limitation on your driver's license to operate? Yes ☐ No ☐ If yes, what is the limitation?
Have you ever been treated for alcohol or drug use? Yes ☐ No ☐ If yes, explain:

Have you ever been denied health or life insurance because of your health? Yes ☐ No ☐
If yes, by which company, and why?

OTHER DAMAGES/MISCELLANEOUS

List here every claim you have ever made for personal injury or property damage:

Date	Against Whom	Type of Claim	Lawsuit Filed	Result

What type of work do you do?
Have you lost any days of work from this injury? Yes ☐ No ☐
If yes, give dates:
Have you lost any overtime from work from this injury? Yes ☐ No ☐
If yes, give dates and times:

Was time off authorized by a doctor? Yes ☐ No ☐

Have you received any increases or decreases in your pay since the accident? Yes ☐ No ☐ If yes, describe:
Have you received Social Security benefits, workers' compensation, or Medicare benefits as a result of this accident? Yes ☐ No ☐
Are your work activities limited due to this accident? Yes ☐ No ☐
Are other activities limited due to this accident? Yes ☐ No ☐ If yes, describe:
Since this injury are your symptoms ☐ improving ☐ worsening ☐ same?
Were others involved or injured at the same time? Yes ☐ No ☐ If yes, describe and provide contact information:
Did you have any property damages as a result of the accident? Yes ☐ No ☐ If yes, describe:

Please provide the following dates and dollar amounts:

Date	Lost Wages	Lost Overtime	Medical Care	Medication/Medical Supplies	Transportation	Other

INSURANCE

Your insurance policy: Carrier: Address:
Medical coverage? Yes ☐ No ☐ If yes, limits: Liability limits:
Claim Number: Insured: Adjuster:
Telephone Number: Ext.

The other party's insurance policy: Carrier: Address:
Medical coverage? Yes ☐ No ☐ If yes, limits: Liability limits:
Claim Number: Insured: Adjuster:
Telephone Number: Ext.
Telephone Number: Ext.

Do you have a criminal record? Yes ☐ No ☐ If yes, please describe: