Product Liability Questionnaire

Your full name: Street address:
City: State: Zip: County:
Birth date: Social Security Number:
Home phone: Work phone: ext. Cell/pager: E-mail:

THE ACCIDENT

Location of the incident:
Date of the accident: Day of the week: Time of day:
Weather conditions:
Describe in detail how the incident occurred:
What type the product (include any details such as manufacturer and brand/model) caused your injury?
How do you think the accident happened?
What could have been done to avoid the accident?
What could have been done to make the accident less severe?

THE PRODUCT

What is your previous knowledge of or experience with the product before you were injured?
Do you know of any modifications or changes that were made to the product? Yes ☐ No ☐ If yes, describe:
Who purchased the product which injured you?
Who owned the product which injured you?
Where was it purchased? Price: Reason for purchase:
Did you receive any warnings or instructions on the use of the product which injured you? Yes ☐ No ☐
If yes, who gave the instructions or warnings?
If yes, what were the instructions or warnings?
If yes, were the instructions or warnings ☐ oral or ☐ written?
Were you using the product under the supervision of anyone? Yes ☐ No ☐ If yes, under whom?
Was the product prescribed by a health-care provider, or recommended by some other professional? Yes ☐ No ☐ If yes, by whom?

THIRD PARTIES

Were you injured while working for an employer? Yes ☐ No ☐ If yes, explain:
Employer's name: Employer's address: Employer's phone number:
Were you injured at the workplace or an outside work site? Yes ☐ No ☐ If yes, explain:
Did your employer own the product that injured you? Yes ☐ No ☐

Did your employer manufacture, distribute, design or produce the product which injured you? Yes ☐ No ☐
Were any co-workers involved? Yes ☐ No ☐ If yes:
Name: Address: How person was involved:

Name: Address: How person was involved:

Name: Address: How person was involved:

Name: Address: How person was involved:

Were there any witnesses? Yes ☐ No ☐ If yes:

Name: Address: Phone Number:

Name: Address: Phone Number:

Name: Address: Phone Number:

Name: Address: Phone Number:

Who do you think is responsible for the accident?
Name: Address: Phone Number:

Any information you have about this person's insurance carrier:

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?

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?

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

Date	Against Whom	Type of Claim	Lawsuit Filed	Result

Are you diabetic? Yes ☐ No ☐
Do you have high blood pressure? Yes ☐ No ☐
Do you have low blood pressure? Yes ☐ No ☐
Do you have arthritis or degenerative joint disease? Yes ☐ No ☐
Are you currently under medical care for injuries due to the accident? Yes ☐ No ☐

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 ☐
Are your work activities limited due to this accident? Yes ☐ No ☐
Have you received any increases or decreases in your pay since the accident? Yes ☐ No ☐ If yes, describe:

Are other activities limited due to this accident? Yes ☐ No ☐ If yes, describe:

Have you received Social Security benefits, worker's compensation, or Medicare benefits as a result of this accident? Yes ☐ No ☐

Since this injury are your symptoms ☐ improving ☐ worsening ☐ same?

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