Matthew D. Kaplan, LLC ATTORNEY AT LAW

KOIN Center Suite 1111
222 SW Columbia Street
Portland, OR 97201
Phone: 503-226-3844
Fax: 503-943-6670
www.MDKAPLANLAW.COM
matthew@mdkaplanlaw.com

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PLEASE TAKE YOUR TIME IN COMPLETING THIS QUESTIONNAIRE. IT IS VERY IMPORTANT TO YOUR CASE THAT THIS INFORMATION IS AS THOROUGH AND ACCURATE AS POSSIBLE.

Medical Malpractice Client Interview Form

DATE OF INCIDENT:_____ TIME OF INCIDENT:_____

NAME: _____ TODAY'S DATE:_____

STREET ADDRESS: _____ SPOUSE/PARTNER:_____

CITY, STATE, ZIP CODE:_____ SOCIAL SECURITY NO:_____

HOME PHONE #:_____ DATE OF BIRTH: _____

WORK PHONE #:_____ AGE: _____

CELL PHONE#:_____ REFERRED BY:_____

MEDICAL MALPRACTICE INFORMATION

WHAT IS THE IDENTITY OF THE DOCTOR AND/OR HOSPITAL IN QUESTION?_____

_____

WHEN DID YOU BEGIN THE MEDICAL TREATMENT IN QUESTION?_____

_____

WHEN DID THE MEDICAL TREATMENT IN QUESTION END?_____

_____

WHAT OCCURRED THAT LEADS YOU TO BELIEVE A HEALTH CARE PROFESSIONAL CAUSED YOU HARM?_____

_____

HAS ANY HEALTH CARE PROFESSIONAL APOLOGIZED FOR THE RESULTS OF YOUR CARE?_____

HAS ANYONE TOLD YOU THAT THE MEDICAL CARE YOU RECEIVED CAUSED YOU AN INJURY?_____

_____

DID YOU SIGN ANY DOCUMENTS ACKNOWLEDGING YOU WERE AWARE OF THE RISKS OF TREATMENT?_____

_____

DID YOU SIGN AN ARBITRATION AGREEMENT PRIOR TO COMMENCING THE MEDICAL CARE?_____

_____

DID YOU HAVE A PRE-EXISTING RELATIONSHIP WITH THE DOCTOR IN QUESTION? _____

_____

WAS THE PHYSICIAN IN QUESTION ASSIGNED TO YOU BY A HOSPITAL?_____

_____

WHY DID YOU GO TO THE DOCTOR/HOSPITAL-EXPLAINED WHAT HAPPENED?_____

_____

_____

WHAT IS THE CURRENT STATUS OF THAT CONDITION?_____

_____

WHAT TREATMENT DID YOU RECEIVE?_____

_____

WHAT WERE THE RESULTS OF THAT TREATMENT?_____

_____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE/WHY?_____

_____

WHAT IS YOUR DIAGNOSIS?_____

_____

WHAT IS YOUR PROGNOSIS?_____