

# Matthew D. Kaplan, LLC

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.

## Personal Injury Client Interview Form

DATE OF ACCIDENT: _____	TIME OF ACCIDENT: _____
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: _____

### DRIVER OF YOUR VEHICLE

NAME: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

STREET: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ PASSENGERS: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_

DESCRIPTION OF VEHICLE: \_\_\_\_\_

LICENSE PLATE NUMBER AND STATE: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

INSURER'S ADDRESS: \_\_\_\_\_

ADJUSTER(S) NAME(S): \_\_\_\_\_

ADJUSTER(S) PHONE #: \_\_\_\_\_ CLAIM # (IF KNOWN) \_\_\_\_\_

-IF DIFFERENT-

OWNER'S NAME: \_\_\_\_\_

OWNER'S ADDRESS: \_\_\_\_\_

**OTHER DRIVER**

NAME: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

STREET: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ PASSENGERS: \_\_\_\_\_

DRIVER'S LICENSE#: \_\_\_\_\_

DESCRIPTION OF VEHICLE: \_\_\_\_\_

LICENSE PLATE NUMBER AND STATE: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

INSURER'S ADDRESS: \_\_\_\_\_

ADJUSTER(S) NAMES(S): \_\_\_\_\_

ADJUSTER(S) PHONE #(S): \_\_\_\_\_ CLAIM # (IF KNOWN): \_\_\_\_\_

-IF DIFFERENT-

OWNER'S NAME: \_\_\_\_\_

OWNER'S ADDRESS: \_\_\_\_\_

**ACCIDENT INFORMATION**

CITY AND COUNTY WHERE ACCIDENT OCCURRED: \_\_\_\_\_

LOCATION OF ACCIDENT: \_\_\_\_\_


WEATHER AND LIGHT CONDITIONS: \_\_\_\_\_

ROAD CONDITIONS: \_\_\_\_\_

POSTED SPEED LIMIT: \_\_\_\_\_

DESCRIBE HOW THE ACCIDENT HAPPENED: \_\_\_\_\_

DRAW A DIAGRAM OF THE ACCIDENT:



DESCRIBE DAMAGE TO YOUR VEHICLE: \_\_\_\_\_

DESCRIBE DAMAGE TO OTHER VEHICLE: \_\_\_\_\_

YOUR ESTIMATE OF REPAIR COST: \_\_\_\_\_

WERE YOU WEARING A SEAT BELT: \_\_\_\_\_

WERE YOU WORKING AT THE TIME: \_\_\_\_\_

WERE YOU AWARE OF THE PENDING CRASH: \_\_\_\_\_

WERE YOU STOPPED, SPEEDING UP, OR SLOWING DOWN AT THE TIME OF IMPACT: \_\_\_\_\_

IF YOUR VEHICLE WAS TOWED, WHO TOWED IT: \_\_\_\_\_

NAME OF POLICE AGENCIES AT THE SCENE: \_\_\_\_\_

WAS ANYONE CITED: \_\_\_\_\_ WHAT FOR: \_\_\_\_\_

WHAT AMBULANCE OR EMT WERE AT THE SCENE: \_\_\_\_\_

HOW DID THE PEOPLE LEAVE THE SCENE (E.G., AMBULANCE, THEIR CAR): \_\_\_\_\_

LIST ANY WITNESSES, THEIR ADDRESSES, AND PHONE NUMBERS:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

**WAGE LOSS**

EMPLOYER'S NAME: \_\_\_\_\_  
EMPLOYER'S ADDRESS: \_\_\_\_\_  
HOURS NORMALLY WORKED PER DAY: \_\_\_\_\_ PER MONTH: \_\_\_\_\_  
INCOME PER HOUR: \_\_\_\_\_ PER MONTH: \_\_\_\_\_  
DATES UNABLE TO WORK DUE TO ACCIDENT: \_\_\_\_\_  
TOTAL INCOME LOSS DUE TO ACCIDENT: \_\_\_\_\_  
DESCRIPTION OF JOB DUTIES: \_\_\_\_\_

**INJURIES**

HEADACHES?	YES _____	NO _____
DIZZINESS?	YES _____	NO _____
NAUSEA?	YES _____	NO _____
RINGING IN EARS?	YES _____	NO _____
BLURRED VISION?	YES _____	NO _____
LOSS OF MEMORY?	YES _____	NO _____
JAW PAIN?	YES _____	NO _____
CLICKING IN JAW?	YES _____	NO _____
EATING/CHEWING DIFFICULTY?	YES _____	NO _____
NECK PAIN?	YES _____	NO _____

SHOULDER PAIN?

YES \_\_\_\_\_

NO \_\_\_\_\_

NUMBNESS ANYWHERE?

YES \_\_\_\_\_

NO \_\_\_\_\_

IF SO, WHERE? \_\_\_\_\_

BACK PAIN?

YES \_\_\_\_\_

NO \_\_\_\_\_

HIP PAIN?

YES \_\_\_\_\_

NO \_\_\_\_\_

OTHER INJURIES: \_\_\_\_\_

## IMPAIRED ACTIVITIES

CIRCLE THOSE THAT APPLY:

### SPORTS:

BADMINTON

AEROBIC EXERCISES

ARCHERY

WATER SKIING

BOXING

BASEBALL

BASKETBALL

BACKPACKING

FISHING

CARD PLAYING

CAMPING

BASKETRY

HANDBALL

FLYING

FOOTBALL

DANCING

JUDO

GYMNASTICS

HEALTH CLUBS

GARDENING

POTTER

HORSEBACK RIDING

ICE SKATING

HOCKEY

YOGA

JOGGING/RUNNING

PHOTOGRAPHY

KARATE

SOCCER

MOUNTAIN CLIMBING

ROWING/BOATING

RACQUETBALL

WALKING

VOLLEYBALL

SOFTBALL

SKIING

WEIGHT LIFTING

BOWLING

BICYCLING

FENCING

GOLF

HUNTING

PAINTING

RAFTING

SAILING

TENNIS

DAY TO DAY ACTIVITIES:

DRESSING

BATHING/SHOWERING

BENDING

VACATION

EATING

CAR WASHING

CHURCH

BRUSHING TEETH

IRONING

HOUSE CLEANING

SHOPPING

LAUNDRY

LIFTING

MOVIE GOING

INDIGESTION

DINING OUT

MOVING

SEXUAL RELATIONS

PLAYING W/ CHILDREN

SLEEPING

STANDING

SHAVING

READING

YARD WORK

TRAVELING

WATCHING TV

SITTING

COOKING

SHAMPOOING HAIR

SOCIAL EVENTS

HOLIDAYS

WORK RELATED ACTIVITIES:

SITTING

WRITING

BENDING

COMPUTER LIFTING

TYPING

STANDING

READING

TELEPHONING

OTHER INJURIES: \_\_\_\_\_

PHYSICIANS/MEDICAL FACILITIES

LIST THE NAMES AND COMPLETE ADDRESSES OF ALL PHYSICIANS AND MEDICAL FACILITIES YOU HAVE SEEN FOR THIS ACCIDENT:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

PREVIOUS INJURIES

LIST ALL PREVIOUS INJURIES (INCLUDING ON THE JOB INJURIES):

DATE	INJURY	PHYSICIAN
1) _____	_____	_____
2) _____	_____	_____

3)

---

PLEASE PROVIDE ANY PHOTOGRAPHS THAT EXIST OF YOUR DAMAGED VEHICLE, THE SCENE OF THE ACCIDENT, AND ANY VISIBLE INJURIES. PLEASE PROVIDE A COPY OF ANY REPAIR ESTIMATES TO YOUR VEHICLE. KEEP AND SEND COPIES OF ALL MEDICAL BILLINGS YOU RECEIVE AND KEEP TRACK OF THE DAYS YOU MISS FROM WORK AS A RESULT OF THIS ACCIDENT.  
THANK YOU.

---