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QUESTIONNAIRE
PERSONAL INJURY AUTOMOBILE CASE

1. Name of Client ____

Address of Client ____

____

Briefly describe the auto accident as it occurred.

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2. Please draw a diagram of the applicable road and the position of your car approaching the accident and the actual place of collision.
Please be sure to label roads, vehicles, and directions which the roads travel.

3. Please circle whether you were the driver or passenger.

Passenger Driver

Also please name all other persons in your vehicle, including where they sat in the vehicle.

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State addresses of people with you in the vehicle and whether they are a relative of yours. If they are a relative, please state how they are related.

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4. State the other driver’s name, address, and insurance information, along with passengers’ names in the other vehicle (if known).

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5. State the year, make, and model of the vehicle involved, and the names of the owners as they are registered.

__________Year ___________________ Make _________________Model

____

____

6. State the time, date, and place of accident.

__________Time _____________ Date ____________________________Place

7. Please state the weather conditions and also the specific road conditions.

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8. Did a law enforcement officer investigate the accident, if so, which municipality? If you recall the name of the officer, please state the officer's name.

______ Yes ______ No ______________________________ Officer's name

_______________________________________ Municipality

9. Have you been contacted by an adjuster? If so, did you give anyone a written or recorded statement? If so, please state when you did this and if you were supplied a copy of the statement.

____ Adjuster

____ Date of statement

_____ Copy of statement _______ No copy of statement ________Copy enclosed

10. Describe the nature of your injuries.

____

____

____

____

____

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____

____

11. What "specialists" have you seen to date? More specifically, please state where you have incurred medical bills, pharmacy bills, and any other bills as a result of this accident.

____

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____

____

Do you anticipate further expenses being incurred? ______ Yes ______ No

12. State who your treating physicians and medical providers are.

____

____

____

____

13. Were you hospitalized? If so, where and for how long?

_____ Yes _____ No Hospital ____________________________________

Period of time _______________________

14. Please state where you are employed and whether you have lost income as a result of this accident. If you have lost income, please state the amount, and the date(s) you lost work.

Place of employment:____

Address:____

Job Title: ____

Hourly wage or salary:____

Amount of income lost:____

Dates of work lost:____

Do you anticipate further loss of wages? ______Yes _______ No

15. What is your marital status, yearly income, number of dependents, educational background, job (career potential) and age?

______ Age _____________ Marital status ____________________ Yearly income

______ # of dependents ____________________________ Job information

Education background ____

16. Do you have any insurance policies (automobile, health, accident, disability, etc)? Please provide us with copies of ALL of your policies.

Automobile

Insurance Company ____

Address and telephone ____
____

Policy # ____

Please provide a copy of the policy.

Health

Insurance Company ____

Address and telephone ____

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Policy # ____

Please provide a copy of the policy.

Disability

Insurance Company ____

Address and telephone ____

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Policy # ____

Please provide a copy of the policy.

Accident

Insurance Company ____

Address and telephone ____

____

Policy # ____

Please provide a copy of the policy.

17. Were there any witnesses to the accident? If so, please list their names and addresses (if known). Please state if you know the witness, aside from this accident.

Name ____

Address ____

Phone # ____

Name ____

Address ____

Phone # ____

Name ____

Address ____

Phone # ____

18. Were there other injuries in the same accident? If so, how many people were hurt and who were they?

______ Yes ______ No ____________ How many

Names:

____

____

____

19. Please state the name of the contact person with your employer to verify time loss from work resulting from this accident, and in order to obtain a statement as to your hourly, weekly, or average wage.

Name: ____

Phone # ____

Title or position ____

20. Please give a brief summary of your past medical history, in terms of times you had to go to the doctor other than for normal physical check-ups.

21. Have you ever made any previous liability claims? ______ Yes ______ No

State the identity of all other insurance companies involved. State how they are related to this case.

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22. How many vehicles do you own? If none, do you live with relatives? If you do live with relatives, state who they are. Do they own any vehicles? If so, please supply any and all insurance policies relating to those vehicles.

___________ Number of vehicles owned

____

____

____

____
Signature

____
Date