

**PERSONAL INJURY/AUTO ACCIDENT  
INTAKE FORM**

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE? \_\_\_ YES \_\_\_ NO

IF SO, PLEASE GIVE NAME OF ATTORNEY: \_\_\_\_\_

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? \_\_\_ YES \_\_\_ NO

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)  
\_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

S.O.L.: \_\_\_\_\_

**CLIENT INFORMATION:**

Client's Name: \_\_\_\_\_

Client's Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Age: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SS# \_\_\_\_\_

**Employer:** \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Fax: \_\_\_\_\_ Work Days/Hours: \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Client's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Client's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Duties: \_\_\_\_\_  
\_\_\_\_\_

Prior **similar injuries**, treated medical conditions and/or symptoms to same area or current injury  
(Dates/Drs.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prior **claims and/or settlements** (types, dates, attorneys):

\_\_\_\_\_  
\_\_\_\_\_

List any **prior injury settlements**:

\_\_\_\_\_  
\_\_\_\_\_

### ACCIDENT INFORMATION

Date of Accident: \_\_\_\_\_ Day of Week: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Where: (Be Specific) \_\_\_\_\_

\_\_\_\_\_



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To whom? \_\_\_\_\_

Were photographs taken of the scene? \_\_\_\_\_

**INSURANCE COVERAGE FOR PLAINTIFF:**

Name of Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Collision coverage amount: \_\_\_\_\_

Deductible Amount: \_\_\_\_\_

Liability Coverage: \_\_\_\_\_

Medical Payment Amount: \_\_\_\_\_

Uninsured Motorist Coverage Amount: \_\_\_\_\_

Cash Policy for Accidents: \_\_\_\_\_

Effective Dates of coverage: \_\_\_\_\_

Is this a WORKE'S COMP CLAIMS? \_\_\_\_\_

Are you covered through your employer's insurance? \_\_\_ Yes \_\_\_ No

If so, provide company and agent, if known: \_\_\_\_\_

Policy or plan number: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Limits of coverage: \_\_\_\_\_

Did you file a claim with your insurance company?  Yes  No

Has anyone from the insurance company contacted you about this claim?  Yes  No

If yes, name of person who contacted you: \_\_\_\_\_

When was contact made? \_\_\_\_\_

If a statement was given, was it tape recorded or written? \_\_\_\_\_

Did you receive a copy?  Yes  No

Have you signed any authorizations to release information to anyone?  Yes  No

If so, identify: \_\_\_\_\_

Have you signed any releases?  Yes  No

If so, for whom? \_\_\_\_\_

Have you received any insurance benefits?  Yes  No

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury?  Yes  No

If so, which agency? \_\_\_\_\_

**INSURANCE COVERAGE FOR DEFENDANT**

Name of Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Collision coverage amount: \_\_\_\_\_

Deductible Amount: \_\_\_\_\_

Liability Coverage: \_\_\_\_\_

Medical Payment Amount: \_\_\_\_\_

Uninsured Motorist Coverage Amount: \_\_\_\_\_

**MEDICAL INFORMATION:**

Were you injured in this accident? \_\_\_ Yes \_\_\_ No

If so, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you go to the hospital? \_\_\_ Yes \_\_\_ No

If so, which hospital: \_\_\_\_\_

Admitted or Outpatient? \_\_\_\_\_

If admitted, release date: \_\_\_\_\_

X-Rays taken? \_\_\_ Yes \_\_\_ No

Were you taken by ambulance? \_\_\_ Yes \_\_\_ No  
(If City of Chicago ambulance, please sign authorization for release form)

Are you under the care of a physician now? \_\_\_ Yes \_\_\_ No

Did you miss work due to the accident? \_\_\_ Yes \_\_\_ No  
(If yes, please

**LIST DOCTORS:**

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_ Yes \_\_\_ No

Current Balance on Medical Bills: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_ Yes \_\_\_ No

Current Balance on Medical Bills: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy? \_\_\_ Yes \_\_\_ No

Current Balance on Medical Bills: \_\_\_\_\_

4. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy?  Yes  No

Current Balance on Medical Bills: \_\_\_\_\_

5. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

When did you last see the doctor? \_\_\_\_\_

When will you see the doctor again? \_\_\_\_\_

Physical therapy?  Yes  No

Current Balance on Medical Bills: \_\_\_\_\_

**PRESCRIPTIONS:** BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING OR WHEN CAST IS REMOVED.

**Was anyone else injured?**  Yes  No

Who was injured? \_\_\_\_\_

Describe the injury: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**NAME AND ADDRESSES OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**WITNESSES:**

1. Name and address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.): \_\_\_\_\_

What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_ Yes \_\_\_ No

2. Name and address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.): \_\_\_\_\_

What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_ Yes \_\_\_ No

3. Name and address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.): \_\_\_\_\_

What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_ Yes \_\_\_ No

4. Name and address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.): \_\_\_\_\_

What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_ Yes \_\_\_ No

5. Name and address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Relationship (fellow employees, supervisors, bystanders, etc.): \_\_\_\_\_

What did each see? \_\_\_\_\_

Would they be willing to testify in court to what he/she saw? \_\_\_ Yes \_\_\_ No

**VIEWING THE SCENE:**

Can we go to the accident scene? \_\_\_ Yes \_\_\_ No

Is the equipment available for inspection? \_\_\_ Yes \_\_\_ No

Who do we contact to arrange a viewing? \_\_\_\_\_

NAME AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Job Title: \_\_\_\_\_

Can we photograph the equipment? \_\_\_ Yes \_\_\_ No

Any other information you feel may assist us in representing you for this claim?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**DIAGRAM OF HOW ACCIDENT OCCURRED:**

**DAMAGES:**

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): \_\_\_\_\_

\_\_\_\_\_

Sports: \_\_\_\_\_

\_\_\_\_\_

Social Activities: \_\_\_\_\_

\_\_\_\_\_

Job Duties: \_\_\_\_\_

\_\_\_\_\_

Household Chores: \_\_\_\_\_

\_\_\_\_\_

Have you had to hire domestic help? \_\_\_ Yes \_\_\_ No

How do you feel you have been damaged emotionally by these injuries? \_\_\_\_\_

\_\_\_\_\_

How do you feel you have been damaged financially by these injuries? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_