

# Personal Injury Information Questionnaire

## CLIENT INFORMATION

Full Legal Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_

Social Security No \_\_\_\_\_

Driver's License No \_\_\_\_\_ State \_\_\_\_\_

Do you have health insurance? YES NO

If the answer is yes, please furnish the following information:

Ins. Company Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

ID/Member/Group number \_\_\_\_\_

Spouse \_\_\_\_\_ Phone \_\_\_\_\_

Please list a contact person who does not reside with you that will always know how to contact you.

Name \_\_\_\_\_

Phone \_\_\_\_\_ Other \_\_\_\_\_

**FACTS ABOUT THE ACCIDENT**

Please furnish all of the details regarding the collision that you can remember. Be as specific as you can with regard to the distance, location of objects and other facts which pertain to your collision.

Date \_\_\_\_\_ Time \_\_\_\_\_

Weather \_\_\_\_\_

Location \_\_\_\_\_

What Happened? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In the space below, please draw an illustration or diagram of the location of the collision and how it happened. Be sure to label the drawing of any object or persons.

**DRIVERS AND OWNERS OF VEHICLES INVOLVED IN COLLISION**

List the driver and owner of each vehicle involved:

***YOUR VEHICLE:***

Driver \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Owner \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

License Plate \_\_\_\_\_ Color \_\_\_\_\_

***OTHER VEHICLE***

Driver \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Owner \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_

License Plate \_\_\_\_\_ Color \_\_\_\_\_

Please provide information for all passengers in your vehicle

Passenger \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Passenger \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Passenger \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Passenger \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Where is your vehicle located? \_\_\_\_\_

Is it drivable?      YES              NO

Do you have photos?      YES              NO

Where is the damage to your vehicle? \_\_\_\_\_

Estimated damage to your vehicle      \$      \_\_\_\_\_

Is there visible damage to other vehicle?              YES              NO

**CLIENT'S AUTOMOBILE INSURANCE**

Did you have auto insurance at the time of the collision?

If so, please furnish the following information:

Name of Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Agent \_\_\_\_\_

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

Liability Limits \_\_\_\_\_

UIM Limits & Coverage \_\_\_\_\_

PIP or Med Pay \_\_\_\_\_

We will file your PIP or Med Pay unless instructed otherwise \_\_\_\_\_

Have you contacted your own insurance company? \_\_\_\_\_

If the answer is yes, please furnish the following contact information:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Claim Number: \_\_\_\_\_

Identity of every other insurance policy carried by Plaintiff or any member of plaintiff's household covering any vehicle owned by any member of the household:

Name of Insured \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy No. \_\_\_\_\_

**OTHER PARTY'S INSURANCE COVERAGE**

Was the other party to the collision insured?  
If so, please furnish the following information:

Name of Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Agent \_\_\_\_\_

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

Liability Limits \_\_\_\_\_

2. Did you contact the other party's insurance company?  
If the answer is yes, please furnish the following contact information for the other party's insurance company:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Claim Number: \_\_\_\_\_

Have you give any recorded or written statement to the adjuster? YES NO

Did you talk to anyone at the scene of the accident? YES NO

Who did you speak with and what was said?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**INJURIES**

Detailed listing of each injury \_\_\_\_\_

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

List the specific parts of your body in which you have pain \_\_\_\_\_

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

**TREATMENT RESULTING FROM CURRENT ACCIDENT**

Ambulance \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Doctor/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Doctor/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Doctor/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Doctor/Clinic \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**WORK BACKGROUND**

Are you presently employed?

Yes

No

If so, please indicate:

Name of Employer

---

Address

---

Phone

---

Job Title and Duties

---

How long have you been employed?

---

What is your rate of pay? Monthly

---

How many hours per week do you work?

---

What was your gross income for the last 12 months?

---

Did you miss any work due to this incident?

YES

NO

If so, please indicate the amount of time you missed.

---

Have you changed your employer or the nature of your work since the date of the accident.

If so, please explain fully the reason for termination or change of work.

---

---

---

---

---

**CLIENT BACKGROUND**

Have you ever been involved in a lawsuit?

YES

NO

If so, please explain:

---

Have you ever filed a claim for a work injury?

YES

NO

If so, please explain:

---

Have you ever filed a claim with an insurance co.?

YES

NO

If so, please explain:

---

Please list any injury/illness you have had in the past 10 years that required treatment by a medical professional:

---

---

---

Have you ever been charged with/convicted of any crime other than minor traffic violations? If so, explain:

---

---

Do you have at least 5 years of tax returns?

YES

NO

If so, please provide them to us as soon as possible.

**LAY WITNESSES**

Please furnish the name of anyone who may know about your injuries. This would include members of your family, neighbors, friends, anyone who may know about your injuries or how they have affected you or what effect they may have on your hobbies, activities, or physical condition in general.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

What do they know? \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

What do they know? \_\_\_\_\_

Is there anything else you feel is important regarding this matter that you would like to share.

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

Referred By: \_\_\_\_\_

Interviewed By: \_\_\_\_\_

Date: \_\_\_\_\_