

—The Law Offices of—
CAL STEINMETZ

PERSONAL INJURY INFORMATION FORM

Instructions: Copy this form to your computer, and then print a hard copy to bring to your meeting. Or, copy the text of this form into an eMail and send it to calmets@aol.com prior to your meeting with an attorney.

CASE INFORMATION – PERSONAL INJURY

NAME: _____

DATE OF ACCIDENT: _____

YOUR INSURANCE
COMPANY: _____

NAME OF OTHER
PERSON: _____

OTHER PERSON'S
INSURANCE CO. _____

PLAINTIFF INFORMATION

1. Full Name _____

2. Birthplace _____

3. Social
Security Number _____

4. Phone No. (w) _____ (h) _____

5. Address _____

6. Birthdate _____

7. Marital Status *(check one)* Single Divorced Separated

8. Spouse's Name _____

9. Names and ages and addresses of all those (including children) who are dependents and your relationship to each.

Name	Address	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WITNESSES

1. Name _____

Address _____

Phone _____ Age _____ Job _____

What does he/she know?

2. Name _____

Address _____

Phone _____ Age _____ Job _____

What does he/she know?

STATEMENTS MADE

Have you talked to a police officer, investigator, insurance adjuster or any other person about the collision? _____

Have you given any written or recorded statement to anyone about accident? _____

If so:

Name of Person: _____

Date given _____

Do you have copy of statement? _____

Persons present at time _____

Did you sign the statement? _____

MILITARY BACKGROUND, LAW ENFORCEMENT AND PRIOR CLAIMS

1. Military Service _____ Date _____

2. Type of Discharge _____

3. Service connected injuries

Details _____

4. V.A., Social Security payments

V.A. Claim No. _____

EDUCATION

List of Schools claimant attended, date, and degrees obtained:

POLICE RECORD

1. Tickets or convictions

Date: _____ Place _____

Charges: _____

Result: _____

2. License restrictions now or in the past: _____

Details: _____

CLAIMS AND LAWSUITS

Previous claims, lawsuits, (including divorce):

1. Date: _____ Place: _____

Against Whom: _____

Nature of Claim: _____

Result: _____

2. Date: _____ Place: _____

Against Whom: _____

Nature of Claim: _____

Result: _____

CLIENT'S INSURANCE

1. Name of Insurance Company: _____

Policy Number: _____

Provisions for medical payments and lost of wages to claimant:

Provisions for uninsured motorist: _____

Provisions for damages to car: _____

Deductible: \$ _____

Amount of insurance if claimant hurts someone else with his car:

2. Accident or Health Insurance: _____

Company & Policy Number: _____

Insurance Agent: _____

AUTOMOBILE ACCIDENT CASES

1. Date: _____ Day: _____ Time: _____

2. Weather: _____

3. Daylight: _____ Dusk: _____ Dark: _____

4. Give exact location and description of what happened: _____

5. Driver of your Vehicle: _____

6. If you were a passenger, state your location in the vehicle: _____

7. If you were a passenger, state with respect to the vehicle:

Insurance company: _____

Name of Policy holder: _____

Policy Number: _____

Provisions for medical payments and lost wages to claimant: _____

Policy holder's state of residence: _____

FACTS CONCERNING THE DEFENDANT

1. Name of other driver: _____

If not the owner of the other vehicle, who was? _____

2. Address: _____

Home Phone # _____ Work Phone # _____

3. Occupation: _____ Age: _____
4. Spouse Name: _____
5. Insurance company: _____
6. Insurance Adjuster: _____
7. Coverage: _____
8. Financial circumstances in regard to any insurance he\she might have: _____
9. Claimant's observations of defendant: _____

MEDICAL HISTORY BEFORE ACCIDENT

1. Previous Hospitalization:

Date Hospital Doctor Duration Nature of illness

2. Previous Physical Examinations (last five years):

Date Place Doctor Purpose

3. Other accidents or injuries (whether claimed or not):

Date Place Nature of Accident Treated by

4. Illnesses or diseases (past five years):

Date Nature of Illness Duration Treated by

5. Chronic health problems: _____

6. Drugs regularly used before accident: _____

7. Insurance declined or canceled: _____ Why? _____

8. Broken bones: _____

Date & Circumstances: _____

9. Normal activities before accident: _____

FALL-DOWN INJURY CASES

1. Description of condition that caused claimant's fall:

2. Any changes in condition since fall? If so what:

3. Any prior accidents before claimant's due to same condition?

If so, name & address of those involved

4. Claimant aware of danger? _____

How often did claimant pass there? _____

When had claimant last passed before accident: _____

Did claimant see danger? _____

Why not? _____

5. What type of shoes claimant was wearing: _____

6. Was claimant carrying anything? _____ Describe _____

7. Lighting and visibility at scene: _____

8. Did claimant rely on direction of anybody else before fall?

Any signs, warnings or notices of danger? _____

9. Light sources: _____

10. Did claimant know how long condition had existed? _____

Source of that knowledge _____

Additional comments _____

List any statements claimant knows about that the defendant has made:

When _____ Where _____

By whom made: _____

DAMAGES FROM ACCIDENT

1. Injuries claimant received as a result of the accident:

2. Claimant's present physical condition - scars, deformities, headaches, pains, etc.

3. Time missed from work:

From _____ To _____

4. Loss of wages to date: _____

5. Any increases or decreases in pay since the accident: _____

6. Pay rate at time of accident: _____

7. Name hospitals where treated or examined:

a. Hospital: _____

Address: _____

From: _____ Total cost: _____

b. Hospital: _____

Address: _____

From: _____ Total cost: _____

c. Hospital: _____

Address: _____

From: _____ Total cost: _____

8. Physicians or surgeons who have treated or examined claimant:

a. Name: _____

Address: _____

Telephone: _____

Treatment rendered:

b. Name: _____

Address: _____

Telephone: _____

Treatment rendered:

c. Name: _____

Address: _____

Telephone: _____

Treatment rendered:

9. Treatment

Back or neck brace: From: _____ To _____

Crutches From: _____ To _____

Traction: From: _____ To _____

Physiotherapy: From: _____ To _____

Other From: _____ To _____

10. Usual activities curtailed or hindered since accident:

11. Time lost from school: _____

12. Period confined to stay home: _____

13. Out-of-Pocket Expenses

Amount Paid:

Physicians & Surgeons: \$ _____

Ambulance: \$ _____

Hospitals: \$ _____

Nurses: \$ _____

Drugs: \$ _____

Crutches, braces, etc.: \$ _____

X-rays: \$ _____

Domestic help: \$ _____

Auto repair: \$ _____

Car rental: \$ _____

Lost Wages: \$ _____

Other: \$ _____

CONCLUSION

Additional Information:

14. List the addresses where claimant has resided during the past ten years with period of the residency, including dates.

Residence (From To)

15. Other names used by claimant:

WORK BACKGROUND

Present job: _____

Name and address of employer:

Present job title & duties: _____

How long at this job: _____ Work Phone: _____

Salary: _____

Employer at time of accident: _____

Address: _____

Job title & type of work: _____

Rate of pay: _____ hours/week _____

Earnings for year before accident occurred: _____

Prior employment:

a. Employer:

Address: _____

Title: _____ Date employed: _____

Reason for departure: _____

Salary: Starting: \$ _____ \$ _____

b. Employer:

Address: _____

Title: _____ Date employed: _____

Reason for departure: _____

Salary: Starting: \$ _____ \$ _____

**** Please bring you insurance policy and coverage to the consultation. ****