

**CLIENT INFORMATION FORM
CASE INFORMATION - PERSONAL INJURY**

Name: _____ Date of Accident: _____

Your Insurance Company: _____

Name of Party: _____

Other Parties Insurance Company: _____

PLAINTIFF INFORMATION

1. Full Name _____

2. Birth date/place _____

3. Social Security Number _____

4. Phone Number (w) _____ (h) _____

5. Address _____

6. Married ___ Single ___ Divorced ___ Separated _____

7. Spouses Name _____

8. Names, ages and addresses of all those (including children) who are dependents and you relationship to each:

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

WITNESSES

1. Name _____ Address _____
Telephone _____ Age _____ Occupation _____
Information they have: _____

2. Name _____ Address _____
Telephone _____ Age _____ Occupation _____
Information he/she has: _____

STATEMENTS

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

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

If yes, please provide the following information:

Name of person: _____

Date of Statement/Conversation: _____

Were you given a copy? _____ Did you sign it? _____

Name (s) of those present: _____

MILITARY BACKGROUND, LAW ENFORCEMENT AND PRIOR CLAIMS

1. Military Service _____ Dates _____
2. Type of Discharge _____
3. Any Service connected injuries _____

4. V.A., Social Security payments _____ V.A. claim No. _____

EDUCATION

Schools Attended	Dates of Attendance	Degrees
_____	_____	_____
_____	_____	_____
_____	_____	_____

POLICE RECORD

1. Tickets or Convictions:
- Date: _____ Charges: _____
- Place: _____ Results: _____
- Date: _____ Charges: _____
- Place: _____ Results: _____
- Date: _____ Charges: _____
- Place: _____ Results: _____

CLAIMS AND LAWSUITS

Please list any claims or lawsuits (including divorce):

Date: _____ Nature of Claim: _____

Place: _____

Against Whom: _____ Result: _____

Date: _____

Date: _____

Place: _____

Place: _____

Against Whom: _____

Against Whom: _____

Nature of Claim: _____

Nature of Claim: _____

Result: _____

Result: _____

Date: _____

Place: _____

Against Whom: _____

Nature of Claim: _____

Result: _____

CLIENT'S INSURANCE

Name of Insurance Company _____

Policy Number _____

Provisions for medical payments and loss of wages to claimant _____

Provisions for uninsured motorists _____

Provisions for damages to vehicle _____

Deductible \$ _____ Amount of Insurance if claimant injures someone else with his/her vehicle \$ _____

Accident or Health Insurance _____ Company/Policy Number _____

Insurance Agent _____

AUTOMOBILE ACCIDENT CASES

1. Date: _____ Day of Week: _____ Time: _____
2. Weather conditions: _____
3. Daylight _____ Dusk _____ Dark _____
4. Provide exact location and description of events: _____

5. Driver of your vehicle : _____
6. If you were a passenger, state your location within the vehicle: _____
7. If you were a passenger, state with respect to the vehicle:
 - a. Insurance Company _____
 - b. Name of Policy Holder _____
 - c. Policy Number _____
 - d. Policy Holder's State of Residence _____
 - e. Provisions for medical payments and lost wages to claimant _____

 - f. Provisions for medical payments an lost wages for uninsured motorist _____

FACTS CONCERNING THE DEFENDANT

1. Name of other driver: _____
If not the owner of the other vehicle, who was: _____
2. Address: _____
Home Telephone: _____ Work Telephone: _____

3. Occupation: _____ Age: _____
4. Marital Status: _____ Married _____ Single _____ Separated _____ Divorced
5. Name of Spouse: _____
6. Insurance Company: _____ Name of Adjuster: _____
7. Coverage: _____
8. Financial circumstances with regard to any insurance he/she might have: _____

9. Claimant's observations of Defendant: _____

Medical History (prior to accident)

1. Hospitalizations:

Date	Hospital	Doctor Name	Duration	Nature of Illness

2. Physical Examinations:

Date	Hospital	Doctor Name	Purpose

3. Other Accidents or injuries: (whether claim was made or not)

Date	Location	Nature of Accident	Treated by whom

4. Illnesses or diseases: (last five years)

Date	Nature of Illness	Duration	Treated by whom

-
-
5. Chronic health problems: _____
 6. Medications used regularly: _____
 7. Has you insurance coverage ever been canceled or withheld and why: _____

 8. Any broken bones, provide dates and 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 what? _____
4. Claimant aware of danger? _____ How often did claimant pass by there? _____ When
had claimant last passed before accident? _____ Did Claimant see danger? _____
Why not? _____
5. What type of shoes was Claimant wearing? _____
6. Was Claimant carrying anything? _____ What? _____
7. Please describe the lighting and visibility at the scene. _____

8. Did Claimant rely on direction of anybody else before fall? _____
9. Light Sources _____
10. Did Claimant know how long condition had existed? _____
 - a. Source of that knowledge _____

- b. Additional comments _____
11. List any statements Claimant knows the Defendant has made _____

- When: _____ Where: _____ Name: _____

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:
Dates: From _____ To _____
4. Loss of wages to date _____
5. Any changes in pay since the accident _____
6. Pay rate at time of accident _____
7. List hospitals where treated or examined:
- | | |
|--------------------|--------------------|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Dates: _____ | Dates: _____ |
| Total Costs: _____ | Total Costs: _____ |