CLIENT INFORMATION FORM

CASE INFORMATION

NAME: _____

DATE OF ACCIDENT: _____

YOUR INSURANCE COMPANY: _____

NAME OF OTHER PERSON: _____

OTHER PERSON'S INSURANCE COMPANY: _____

PLAINTIFF INFORMATION

1. Full Name _____
2. Birthplace _____
3. Social Security Number _____ 4. Phone No. _____
5. Address _____

   _____
6. Birth Date _____
7. Mother's Name _____
8. Father's Name _____
9. Marital: _____

   Married ____•____ Single _____. Divorced _____ Separated _____

   Widow _____ Widower _____
10. If divorced, date and place: _____
11. If spouse deceased, date of death: _____
12. Names and ages and addresses of all those (including children) who are dependents and your relationship to each.

Name	Address	Age	Relationship

FORM 2

13. List the addresses where claimant has resided during past 10 years with period of the residency . . . including dates.

Residence	From	To

14. Other names used by claimant:

Where _____ Why _____

15. Married _____ Date of Marriage _____
Place of Marriage _____

WORK BACKGROUND

1. Present job: _____
2. Name and address of employer: _____
3. Present job title and duties: _____
4. How long at this job _____
5. Phone: _____ 6. Salary: _____
7. Employer at time of accident: _____
a. Address: _____
b. Job title and type of work _____
c. Rate of pay _____ d. Hours/week _____
e. Began work on: _____ f. Left work _____
g. Why claimant left this job: _____
8. Earnings for year before accident occurred: _____
9. Prior Employment for past five years:

Name	Address	Date Employed	Job

10. Spouse's employment: Employer _____
Employer's Address: _____

Wages $_____ per _____ Average income entire year for spouse $_____
How long employed _____ Prior Employment _____

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 or Injury	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 and circumstances _____

9. Normal activities before accident: _____

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. _____

POLICE RECORD

1. Tickets or convictions:

Date	Place	Charges	Result

2. License restrictions now or in past: _____ Details: _____
   _____
   _____

CLAIMS AND LAWSUITS

Previous claims, lawsuits, (including divorce):

Date	Place	Against Whom	Nature of Claim	Result

CLIENT'S INSURANCE

1. Name of insurance company and policy number: _____
   _____
2. Provisions for medical payments to claimant _____
3. Provisions for collision with uninsured motorist _____
4. Provisions for damages to car _____ Deductible $ _____
5. Amount of insurance if claimant hurts someone else with his car: _____

6. Accident or Health insurance: _____ Company & Policy Number _____

_____

7. Insurance Agent: _____

EDUCATION

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

_____

_____

_____

* * *

FACTS OF THE ACCIDENT

1. Date: _____ Day: _____ Time: _____
2. Weather: _____
3. Daylight _____ Dusk _____ Dark _____
4. Give exact location and description of what happened:

_____

_____

_____

_____

Diagram:

FACTS CONCERNING THE DEFENDANT

1. Name of other party: _____
2. Address: _____

_____ Phone No. _____

3. His job: _____
4. Age: _____ 5. Wife's name: _____
6. His insurance company: _____
7. His insurance adjuster: _____
8. His coverage: $_____
9. Financial circumstances in regard to any insurance he might have: _____

_____

10. Claimant's observations of defendant: _____

_____

AUTOMOBILE CASE

1. Make of claimant's car: _____
2. Operator of car: _____
3. License No. : _____
4. Damage to car: _____
5. Did claimant have to rent another car: _____ If so, give name of rental and amount of the rental: _____
6. Make of other Party's car _____ License No. _____
7. Operator of other car: _____
8. Damage to other car: _____
9. Investigation conducted by: _____
   Police officer _____ State Patrol _____ City Police _____ Sheriff _____
10. Parts of auto collided: _____
11. How far did cars travel after impact: _____
12. Position of vehicles after impact: _____
13. Skid marks? _____ How did claimant leave scene of accident: _____
    _____
14. Passengers in claimants car:

Name	Address	Where Seated

15. How did cars leave scene of accident (if towed, by whom and where taken): _____
    _____

AUTOMOBILE - PEDESTRIAN CASE

1. Painted crosswalk? _____ Your position in relation to it: _____

_____

2. Extent of traffic _____

3. Traffic signs _____

Location _____

Describe _____

4. Traffic Lights: _____ Location _____

5. Direction traffic was moving _____

6. Obstructions to view _____

7. Re: Car that struck claimant:

Did it stop _____ Did it swerve _____ Lights on _____ Horn _____

Signal given _____ Driver competent _____

Struck by what part of vehicle _____

Could driver have avoided claimant _____

Condition of claimant's eyesight _____

Clothes claimant was wearing _____

Distance of vehicle when claimant first saw it _____

Claimant's Actions _____

_____

_____

FALL-DOWN INJURY CASE

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, names and addresses 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 was claimant wearing: _____
6. Claimant carrying anything _____ What _____
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: _____

WITNESSES

Name _____

Address _____

_____ Phone _____

Age _____ Job _____ What does he know: _____

_____

Name _____

Address _____

_____ Phone _____

Age _____ Job _____ What does he know: _____

_____

Name _____

Address _____

_____ Phone _____

Age _____ Job _____ What does he know: _____

_____

Name _____

Address _____

_____ Phone _____

Age _____ Job _____ What does he know: _____

_____

STATEMENTS MADE

Has claimant talked to police officer, investigator, insurance adjuster or any other person about collision _____

Has claimant given any written statement to anyone about accident? _____

If so:

Name of Person _____

Date given _____

Does claimant have copy of statement _____

Persons present at time _____

Did claimant sign statement _____

List any statements claimant knows about that defendant has made:

_____

_____

When and Where made: _____

Name and address of person who heard it: _____

_____

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. Hospitals where treated or examined:

Hospital: _____

Address: _____

From: _____

Total Costs: _____

Hospital : _____

Address: _____

From: _____ To: _____

Total Costs: _____

Hospital : _____

Address: _____

From: _____ To: _____

Total Costs: _____

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

Doctor's Name: _____

Address: _____

Telephone Number _____

Treatment rendered _____

Doctor's Name: _____

Address: _____

Telephone Number _____

Treatment rendered _____

Doctor's Name: _____

Address: _____

Telephone Number _____

Treatment rendered _____

8. Treatment: Dates:

Back or neck brace:	From _____ To _____
Crutches:	From _____ To _____
Traction:	From _____ To _____
Physiotherapy:	From _____ To _____
Other:	From _____ To _____

9. Usual activities curtailed or hindered since accident:

_____

_____

10. Time lost from school _____

11. Period confined to home _____

Out-of-Pocket Expenses:	Amount	Paid
Physicians and surgeons	_____	_____
Ambulance	_____	_____
Hospitals	_____	_____
Nurses	_____	_____
Drugs	_____	_____
Crutches, braces, etc.	_____	_____
X-rays	_____	_____
Domestic Help	_____	_____
Auto Repair	_____	_____
Car Rental	_____	_____
Lost Wages	_____	_____
Other _____	_____	_____

CONCLUSION

Any Additional Information: _____