[Name of Law Firm]
Attorneys at Law

Questionnaire

The information contained in this questionnaire is for the use of our office only for the evaluation and preparation of your claim. The answers you give will be held in strict confidence and will not be released to unauthorized persons.

Please answer *every* question that applies to you fully and accurately. If more space is needed, use the reverse side of the page.

Today's Date: _____

PART I. PERSONAL DATA

Your Full Name: _____

Street Address: _____

City, State, Zip: _____

Home Telephone: _____ Work Telephone: _____

Your Age: _____ Date of Birth: _____ SS# _____

Spouse's Full Name: _____

Age: _____ Date of Birth: _____ SS# _____

How did you hear of this office? _____

PART II. ACCIDENT/INCIDENT INFORMATION

Date: _____ Time: _____ AM PM City/State: _____

Specific Location: _____

Describe the accident/incident in as much detail as you can:

_____

_____

_____

_____

Sample
Sample

How did the accident happen?

_____

_____

What were the weather and surface conditions at the time of the accident/incident?

_____

_____

Who was injured? _____

Describe the injuries:

_____

_____

Did the police investigate? YES NO Which branch/department? _____

Was a police report made? YES NO Were photographs taken? YES NO

Do you have copies of report(s) or photographs? YES NO

PART III. MEDICAL

What medical treatment have you received?

Date Where (hospital/doctor) Treatment Cost

_____

_____

_____

_____

Will you need treatment in the future? YES NO

If yes, describe treatment you anticipate:

_____

_____

List prior injuries and/or claims:

_____

_____

Sample

PART IV. VEHICLE INFORMATION

Your Vehicle: Make: _____ Model: _____ Year: _____

License plate number: _____ Registered? YES NO In what state? _____

Your automobile insurance company: _____

Your policy number: _____

Your agent or adjuster & phone no., if known: _____

Other policies which may apply such as where owner and operator are different parties:

_____

_____

Other Vehicle: Make: _____ Model: _____ Year: _____

License plate number: _____ Registered? YES NO In what state? _____

Other vehicle insurance company: _____

Other vehicle insurance policy number: _____

Other vehicle insurance adjuster name: _____

Against whom do you believe you have a claim? _____

PART V. EMPLOYMENT

Were you employed on the date of accident? YES NO

Are you working now? YES NO

If NO, when did you stop working (date)? _____

Did a doctor tell you not to work? YES NO

If YES, who? _____

Current Employer: _____

Address: _____

_____

Telephone: _____

Sample

Job Title: _____ Date of Employment: _____ Rate of Pay: _____

What are your job duties?

_____

_____

Previous Employment for the past five (5) years:

1. _____

2. _____

3. _____

4. _____

Spouse's Employer: _____

Address: _____

_____

Telephone: _____

Job Title: _____ Date of Employment: _____ Rate of Pay: _____

PART VI. CHILDREN AND/OR DEPENDENTS

Name	Age	Date of Birth	Living with you now?	
1.			YES	NO
2.			YES	NO
3.			YES	NO
4.			YES	NO

Is there any additional information that you would like us to know about or think we should know about?

Sample