Matthew D. Kaplan, LLC

PLEASE TAKE YOUR TIME IN COMPLETING THIS QUESTIONNAIRE. IT IS VERY IMPORTANT TO YOUR CASE THAT THIS INFORMATION IS AS THOROUGH AND ACCURATE AS POSSIBLE.

Personal Injury Client Interview Form

DATE OF ACCIDENT:_____ TIME OF ACCIDENT:_____
NAME:_____ TODAY'S DATE:_____
STREET ADDRESS:_____ SPOUSE/PARTNER:_____
CITY, STATE, ZIP CODE:_____ SOCIAL SECURITY NO:_____
HOME PHONE #:_____ DATE OF BIRTH: _____
WORK PHONE #:_____ AGE: _____
CELL PHONE#:_____ REFERRED BY:_____

DRIVER OF YOUR VEHICLE

NAME:_____ POLICY HOLDER:_____

STREET:_____

ADDRESS:_____

CITY, STATE, ZIP CODE:_____

PHONE #:_____ PASSENGERS:_____

DRIVER'S LICENSE #:_____

DESCRIPTION OF VEHICLE:_____

LICENSE PLATE NUMBER AND STATE:_____

INSURANCE CARRIER:_____

INSURER'S ADDRESS:_____

ADJUSTER(S) NAME(S):_____

ADJUSTER(S) PHONE #:_____ CLAIM # (IF KNOWN)_____

-IF DIFFERENT-

OWNER'S NAME:_____

OWNER'S ADDRESS:_____

OTHER DRIVER

NAME:_____ POLICY HOLDER:_____

STREET:_____

ADDRESS:_____

CITY, STATE, ZIP:_____

PHONE #:_____ PASSENGERS:_____

DRIVER'S LICENSE#:_____

DESCRIPTION OF VEHICLE:_____

LICENSE PLATE NUMBER AND STATE:_____

INSURANCE CARRIER:_____

INSURER'S ADDRESS:_____

ADJUSTER(S) NAMES(S):_____

ADJUSTER(S) PHONE #(S):_____ CLAIM # (IF KNOWN): _____

-IF DIFFERENT-

OWNER'S NAME:_____

OWNER'S ADDRESS:_____

ACCIDENT INFORMATION

CITY AND COUNTY WHERE ACCIDENT OCCURRED:_____

LOCATION OF ACCIDENT:_____

_____

WEATHER AND LIGHT CONDITIONS:_____

ROAD CONDITIONS:_____

POSTED SPEED LIMIT:_____

DESCRIBE HOW THE ACCIDENT HAPPENED:_____

_____

DRAW A DIAGRAM OF THE ACCIDENT:

DESCRIBE DAMAGE TO YOUR VEHICLE:_____

_____

DESCRIBE DAMAGE TO OTHER VEHICLE:_____

_____

YOUR ESTIMATE OF REPAIR COST:_____

WERE YOU WEARING A SEAT BELT:_____

WERE YOU WORKING AT THE TIME:_____

WERE YOU AWARE OF THE PENDING CRASH:_____

WERE YOU STOPPED, SPEEDING UP, OR SLOWING DOWN AT THE TIME OF IMPACT:_____

_____

IF YOUR VEHICLE WAS TOWED, WHO TOWED IT:_____

NAME OF POLICE AGENCIES AT THE SCENE:_____

WAS ANYONE CITED:_____WHAT FOR:_____

WHAT AMBULANCE OR EMT WERE AT THE SCENE:_____

HOW DID THE PEOPLE LEAVE THE SCENE (E.G., AMBULANCE, THEIR CAR): _____

_____

LIST ANY WITNESSES, THEIR ADDRESSES, AND PHONE NUMBERS:

1._____

2._____

3._____

4._____

WAGE LOSS

EMPLOYER'S NAME:_____

EMPLOYER'S ADDRESS:_____

HOURS NORMALLY WORKED PER DAY:_____ PER MONTH:_____

INCOME PER HOUR:_____ PER MONTH:_____

DATES UNABLE TO WORK DUE TO ACCIDENT:_____

TOTAL INCOME LOSS DUE TO ACCIDENT:_____

DESCRIPTION OF JOB DUTIES:_____

INJURIES

HEADACHES?	YES_____	NO_____
DIZZINESS?	YES_____	NO_____
NAUSEA?	YES_____	NO_____
RINGING IN EARS?	YES_____	NO_____
BLURRED VISION?	YES_____	NO_____
LOSS OF MEMORY?	YES_____	NO_____
JAW PAIN?	YES_____	NO_____
CLICKING IN JAW?	YES_____	NO_____
EATING/CHEWING DIFFICULTY?	YES_____	NO_____
NECK PAIN?	YES_____	NO_____

SHOULDER PAIN?	YES_____	NO_____
NUMBNESS ANYWHERE?	YES_____	NO_____
IF SO, WHERE?_____		
BACK PAIN?	YES_____	NO_____
HIP PAIN?	YES_____	NO_____

OTHER INJURIES:_____

IMPAIRED ACTIVITIES

CIRCLE THOSE THAT APPLY:

SPORTS:

BADMINTON	AEROBIC EXERCISES	ARCHERY	WATER SKIING
BOXING	BASEBALL	BASKETBALL	BACKPACKING
FISHING	CARD PLAYING	CAMPING	BASKETRY
HANDBALL	FLYING	FOOTBALL	DANCING
JUDO	GYMNASTICS	HEALTH CLUBS	GARDENING
POTTER	HORSEBACK RIDING	ICE SKATING	HOCKEY
YOGA	JOGGING/RUNNING	PHOTOGRAPHY	KARATE
SOCCER	MOUNTAIN CLIMBING	ROWING/BOATING	RACQUETBALL
WALKING	VOLLEYBALL	SOFTBALL	SKIING
WEIGHT LIFTING	BOWLING	BICYCLING	FENCING
GOLF	HUNTING	PAINTING	RAFTING
SAILING	TENNIS		

DAY TO DAY ACTIVITIES:

DRESSING	BATHING/SHOWERING	BENDING	VACATION
EATING	CAR WASHING	CHURCH	BRUSHING TEETH
IRONING	HOUSE CLEANING	SHOPPING	LAUNDRY
LIFTING	MOVIE GOING	INDIGESTION	DINING OUT
MOVING	SEXUAL RELATIONS	PLAYING W/ CHILDREN	SLEEPING
STANDING	SHAVING	READING	YARD WORK
TRAVELING	WATCHING TV	SITTING	COOKING
SHAMPOOING HAIR	SOCIAL EVENTS	HOLIDAYS	

WORK RELATED ACTIVITIES:

SITTING	WRITING	BENDING	COMPUTER LIFTING
TYPING	STANDING	READING	TELEPHONING

OTHER INJURIES:_____

PHYSICIANS/MEDICAL FACILITIES

LIST THE NAMES AND COMPLETE ADDRESSES
OF ALL PHYSICIANS AND MEDICAL FACILITIES YOU HAVE SEEN FOR THIS ACCIDENT:

1)_____

2)_____

3)_____

4)_____

5)_____

PREVIOUS INJURIES

LIST ALL PREVIOUS INJURIES (INCLUDING ON THE JOB INJURIES):

DATE INJURY PHYSICIAN

1)_____

2)_____

3)_____

PLEASE PROVIDE ANY PHOTOGRAPHS THAT EXIST OF YOUR DAMAGED VEHICLE, THE SCENE OF THE ACCIDENT, AND ANY VISIBLE INJURIES. PLEASE PROVIDE A COPY OF ANY REPAIR ESTIMATES TO YOUR VEHICLE. KEEP AND SEND COPIES OF ALL MEDICAL BILLINGS YOU RECEIVE AND KEEP TRACK OF THE DAYS YOU MISS FROM WORK AS A RESULT OF THIS ACCIDENT.
THANK YOU.