Case # ___________ Paralegal / Attorney: ______________	Completed By: __________ English / Spanish / Bilingual Needs Contracts: YES / NO

PERSONAL INJURY CHECK SHEET

____ **vs.** ____

DATE CASE RECEIVED: __________________ **REFERRAL BY:**______________________________

DATE OF ACCIDENT: ____________________ **POLICE AT SCENE:**___________________________

TIME OF ACCIDENT: ____________________ **ACCIDENT REPORT #:** ________________________

LOCATION OF ACCIDENT: ____

PLAINTIFF:

NAME: ____ D/Birth: ____________________

ADDRESS:____ SS # : _____________________

CITY: _____________________________ STATE:______________ ZIP:_________________________

TELEPHONE: (Home) _________________ (Work) _________________(Cell) _________________

E-MAIL ADDRESS: ____

YOUR NEAREST LIVING RELATIVE: ____

THEIR ADDRESS: ___________________________________THEIR PHONE: __________________

ALL SOCIAL MEDIA ACCOUNTS

FACEBOOK: _________________________________ OTHER: _________________________________

FACTS OF ACCIDENT: (Please give brief description of how the accident happened)

____

____

____

INFORMATION NEEDED REGARDING HOME / BUILDING INVOLVED IN ACCIDENT:

TYPE OF HOME / BUILDING ____

OWNERSHIP: ____

OWNER'S ADDRESS: ____

ARE THERE PHOTOS OF THE ACCIDENT SITE: ____

WITNESSES AT SCENE: ____

OTHER INFORMATION:

AT THE TIME OF THIS ACCIDENT, WERE YOU ON THE JOB? Yes ❑ No ❑

IF SO, ARE YOU MAKING A CLAIM FOR WORKER'S COMP. BENEFITS? Yes ❑ No ❑

ARE YOU COVERED UNDER ANY OTHER INSURANCE PROGRAM? Yes ❑ No ❑

WHAT WAS THE WEATHER AT THE TIME OF THE ACCIDENT?________________________

PLAINTIFF'S HEALTH INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: ________________________

ADDRESS OF INS. CO. ________________________

CITY: ____________ STATE: ____________ ZIP: ____________

POLICY NO: ____________ DEDUCTIBLE: Yes ❑ No ❑

HAVE YOU NOTIFIED YOUR INSURANCE CARRIER ABOUT THIS ACCIDENT? Yes ❑ No ❑

YOUR INJURIES AS A RESULT OF THIS ACCIDENT:

____

____

____

HAVE YOU HAD PHOTOS TAKEN OF YOUR INJURIES? Yes ❑ No ❑

AMBULANCE: Yes ❑ No ❑ **NAME OF HOSPITAL**:________________________

ADMITTED: Yes ❑ No ❑ **LENGTH OF STAY**: ________________________

YOUR DOCTORS **THEIR ADDRESSES / PHONE NUMBER**

____

____

____

REFERRED TO: ________________________

MEDICAL HISTORY PRIOR TO ACCIDENT: (List **ALL** hospitalizations, back injuries, surgeries, including births, etc.) ________________________

____

____

____

HISTORY:

SINGLE: ❑ MARRIED: ❑ DIVORCED: ❑ WIDOWED: ❑

SPOUSE'S NAME: ______________________________

CHILDREN: NAME AGE

____

____

____

____

EDUCATIONAL BACKGROUND:

SCHOOLS ATTENDED GRADUATED CERTIFICATES/DEGREES EARNED

____

____

____

EMPLOYMENT HISTORY: (List ALL employers for the present and past 20 years)

PRESENT EMPLOYER: ______________________________

ADDRESS & PHONE: ______________________________

POSITION HELD: ______________ JOB DESCRIPTION: ______________

DATE EMPLOYED: ______________ RATE OF PAY: ______________

DATES MISSED FROM WORK: ______________ WAGES LOST (IF KNOWN): ______________

PREVIOUS EMPLOYER: ______________________________

ADDRESS & PHONE: ______________________________

POSITION HELD: ______________ HOW LONG: ________ RATE OF PAY: _______

SELF EMPLOYED Yes ❑ No ❑ OTHER INCOME: ______________

CAN YOU PROVIDE YOUR LAST FIVE YEARS TAX RETURNS? Yes ❑ No ❑

RECREATIONAL ACTIVITIES: ______________________________

____

AS A RESULT OF THIS ACCIDENT HOW HAVE YOUR ACTIVITIES BEEN LIMITED: ____________

____

____

DEFENDANT / OWNER of HOME or BUILDING:

NAME: ______________________________

STREET ADDRESS: ______________________________

CITY: ______________ STATE: __________ ZIP: __________

INSURANCE COMPANY: ______________________________

ADDRESS: ______________________________

CITY: ______________ STATE: __________ ZIP: __________

POLICY NO.: ______________ LIMITS: ______________

ADJUSTER: ______________ PHONE: ______________

CLAIM NO: ______________ FAX: ______________

WERE POLICE CHARGES MADE AGAINST DEFENDANT? Yes ❑ No ❑

IF SO WHAT WERE THE CHARGES: ______________________________

MISC. INFORMATION: ______________________________

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