

Interview Form

Personal Injury Case

1. Personal and Family History

Full Name: _____

Home address: _____

Business address: _____

Home phone: _____ Business phone: _____

E-Mail: _____

2. Date of Injury or Accident

Date of Incident: _____

Location of Accident: _____

Names and addresses (if known) of other people involved:

3. List all other names by which you have ever been known. Include marital and maiden names, nicknames, and aliases:

4. List the addresses where you have resided during the past 10 years. Indicate the period of time at each residence, including dates:

5. Place and Date of Birth: _____

6. Are you presently married? Yes No (Circle One)

Date of Marriage: _____ Place of Marriage: _____

Full name of spouse: _____

Have you ever been divorced or legally separated? Provide details:

7. List the names, ages, and addresses of everyone including children who are dependent upon you for support, and your relationship to each:

Name	Address	Age	Relationship
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8. Employment History

Social Security Number: _____

Most Recent Employer: _____

Employer Address: _____

Beginning Date: _____ Ending Date: _____

Job Description: _____

Beginning Pay Rate: _____ Current Pay Rate: _____

Have you ever missed work due to your injuries? Yes No (Circle One)

If yes, list the dates you were unable to work:

From: _____ To: _____

Reason for leaving job: _____

Employer Prior to last one listed: _____

Prior Employer's Address: _____

Beginning Date: _____ Ending Date: _____

Job Description: _____

Beginning Pay Rate: _____ Ending Pay Rate: _____

Have you ever missed work due to your injuries? Yes No (Circle One)

If yes, list the dates you were unable to work:

From: _____ To: _____

Reason for leaving job: _____

Employer Prior to last one listed: _____

Prior Employer's Address: _____

Beginning Date: _____ Ending Date: _____

Job Description: _____

Beginning Pay Rate: _____ Ending Pay Rate: _____

Have you ever missed work due to your injuries? Yes No (Circle One)

If yes, list the dates you were unable to work:

From: _____ To: _____

Reason for leaving job: _____

[Have client bring in Tax Returns for prior years.]

9. Education

List your highest educational level (high school, college, graduate school, professional training) with the name/address of the institution(s):

Do you have any special job training? Describe: _____

10. Military Background

Have you ever been in the military? Yes No (Circle One)

Service Number: _____ Type of Discharge: _____

Branch: _____ Dates of Service: _____

Have you had any service-related injuries/disabilities? Explain: _____

Percentage of Disability: _____

Present condition of service-related injury/disability: _____

Do you receive payments for service-related injuries? Yes No (Circle One)

If yes, explain: _____

Have you ever been rejected for military service because of physical, mental, or other reasons?

Yes No (Circle One) If yes, explain: _____

11. Prior Claims and Lawsuits

(Our adversaries will inquire about your history of legal claims and lawsuits. It is important that you disclose your complete history to us. It is not fatal if you have been involved in prior legal actions. You won't be penalized by a court or jury if the claims were reasonable and genuine.)
List every claim you have ever made for personal injury or property damage. Give details. (Attach additional page if necessary.)

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

Date: _____ Nature of Claim: _____
Against Whom: _____
Result: _____

12. Police Record

(The defense will investigate your background. We must be prepared against any unfavorable evidence that is uncovered. Evidence of prior criminal acts might be used against you at trial, no matter how mitigating the circumstances.)

List all prior arrest information:

Date	Place	Charge	Result
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Workers' Compensation

Have you ever made a claim for workers' compensation? _____

What was your injury? _____ Date of injury: _____

Are you presently receiving payments? Yes No (Circle One) If yes, explain: _____

Who is handling your workers' compensation action? _____

Are you receiving disability payments from sources other than worker's compensation? Yes

No (Circle One) If yes, explain: _____

14. Prior Physical Conditions

List every physical examination you ever had during the last 10 years for any purpose, including employment, promotion, insurance, selective service, and armed forces. (Attach additional page if necessary.)

Date: _____ Place: _____

Name of Doctor: _____

Purpose: _____ Result: _____

Date: _____ Place: _____

Name of Doctor: _____

Purpose: _____ Result: _____

Date: _____ Place: _____

Name of Doctor: _____

Purpose: _____ Result: _____

Date: _____ Place: _____

Name of Doctor: _____

Purpose: _____ Result: _____

Date: _____ Place: _____

Name of Doctor: _____

Purpose: _____ Result: _____

15. Prior Accidents and Injuries

(Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem.)

List all prior accidents, whether they resulted in a claim for damages or not.

Date	Place	Nature of Accident	Extent of injuries
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Illness or Disease

(We must know about all prior illnesses, either before or since your accident. This is particularly true if there is any connection with your present physical complaints. The defendant will have access to a complete history of your past physical condition as well as your veteran's records, insurance records, and medical/hospital records.)

Date: _____ Nature of Illness: _____

Duration: _____ Treated by: _____

Hospitalized? _____ When? _____

Name/address of hospital: _____

Date: _____ Nature of Illness: _____

Duration: _____ Treated by: _____

Hospitalized? _____ When? _____

Name/address of hospital: _____

Date: _____ Nature of Illness: _____

Duration: _____ Treated by: _____

Hospitalized? _____ When? _____

Name/address of hospital: _____

Date: _____ Nature of Illness: _____

Duration: _____ Treated by: _____

Hospitalized? _____ When? _____

Name/address of hospital: _____

Date: _____ Nature of Illness: _____
Duration: _____ Treated by: _____
Hospitalized? _____ When? _____
Name/address of hospital: _____

Have you ever had trouble with your eyes? _____ Ears? _____

Please check all that apply:

Glasses/contacts: _____ Artificial eye: _____ Hearing aid: _____

Have you ever worn a brace or back and neck support? _____

Have you ever worked with radioactive substances, asbestos, or any other substance alleged to cause diseases, such as cancer? _____

Have you ever been denied health or life insurance? _____ If so, by which company? Give details: _____

Have you ever been treated for alcoholism, drug addition or venereal disease?

17. The Injury

State all injuries known to be a result of the accident:

Length of time confined to bed: _____

Length of time confined to house: _____

State present physical conditions, including scars, disabilities, deformities and discomforts due to the injuries: _____

18. Physicians and Surgeons

List all physicians and surgeons you have seen (attach additional page if necessary):

Name: _____

Address: _____

Nature of treatment: _____

Still under care? Explain: _____

Name: _____

Address: _____

Nature of treatment: _____

Still under care? Explain: _____

Name: _____

Address: _____

Nature of treatment: _____

Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

19. **Nurses, Therapists and Health Care Professionals**
List all nurses, therapists, and health care professionals other than doctors and surgeons that you have seen (attach additional page if necessary):

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

Name: _____
Address: _____
Nature of treatment: _____
Still under care? Explain: _____

ATTACH TO THIS INTERVIEW FORM:

Motor Vehicle Accident Report
Medical Authorization Form
Wage Verification Form