

AGR LAW

Date: _____

Referred By: _____

PERSONAL INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Date of Birth: _____ Social Security No.: _____

Email: _____

What is your preferred method of contact? Phone Email

EMERGENCY CONTACT INFORMATION:

How can we contact you at all times? (Relative or friend who can always locate you)

Name: _____ Relationship: _____

Phone Number: _____

EMPLOYER: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Occupation: _____ How long worked for employer? _____

Immediate Supervisor: _____

Estimated amount of lost income: \$ _____

Did the accident occur in the course of your employment? Yes No

Were you prevented from working as a result of this incident? Yes No

If yes, for how long and on whose advice?

If you did not lose any time as a result of your injuries, did any physician tell you not to work? If yes, please identify the physician, the reason you were told not to work and the reason why you worked despite these instructions.

INSURANCE INFORMATION

Your Car Insurance Company: _____ Full Tort Limited Tort

Policy No.: _____ Claim No. _____

1. Are you covered under your employer's insurance? Yes No

If yes, please provide company and agent and the policy/plan number.

2. Has anyone from an insurance company contacted you about this claim?

Name: _____ Phone No.: _____

3. Did you give a statement to anyone? If yes, who?

4. Did you receive a copy of the statement? Yes No

Your Health Insurance Company:

Policy No. _____

Name of Opposing Party's Insurance: _____

Policy No.: _____ Claim No. _____

4. Was there construction in the area? Yes No
5. Did anyone make a statement at the scene? Yes No
- If Yes, who made the statement and what did they say?

6. Did police investigate the incident? Yes No
- If yes, state in detail what you told the police and any statements you overheard being told to police.

7. Is this a Worker’s Compensation Claim? Yes No
8. Is the vehicle available for inspection? Yes No

PRIOR SIMILAR INJURIES/MEDICAL CONDITIONS/SYMPTOMS to same area or current injury.

Please provide Dates/Doctors.

1. Have you ever had trouble with your eyes? Yes No
 Glasses/contacts? Yes No
2. Have you ever had trouble with your ears? Yes No
 Hearing aids? Yes No
3. Have you ever work a brace or back and neck support? Yes No

MILITARY BACKGROUND (SKIP IF NOT IN THE MILITARY)

Branch: _____ Type of Discharge: _____

Have you had any service-related injuries/disabilities? Yes No

If yes, please explain:

PRIOR CLAIMS AND LAWSUITS (SKIP IF NO OTHER CLAIMS)

List every claim you have ever made for personal injury or property damage.

Date: _____ Type of Claim: _____
Defendant: _____ Result: _____

Date: _____ Type of Claim: _____
Defendant: _____ Result: _____

Date: _____ Type of Claim: _____
Defendant: _____ Result: _____

POLICE RECORD (SKIP IF NO RECORD)

List all prior arrest information.

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

PLEASE PROVIDE COPIES OF ALL PHOTOS IN YOUR POSSESSION.

Were photos taken of the scene? By whom? _____

Were photos taken of the vehicles? By whom? _____

Were photos taken of you injuries? By whom? _____

MEDICAL INFO:

1. Were you injured as a result of the accident? _____

If yes, Please describe:

2. Were you taken to the hospital by ambulance? Yes No

If yes, what was the name of the ambulance company?

3. Did you go to the hospital? If so, what was the name?

4. Admitted or Outpatient? _____

5. X-Rays taken? Yes No

6. Are you currently under a doctor's care now? If so, what is their name?

7. Estimated amount of medical expenses incurred to date: \$ _____

LIST ALL DOCTORS/CHIROPRACTORS, HOSPITALS, ETC. YOU HAVE SEEN FOR THIS ACCIDENT.

1. Name: _____ Phone: _____

Address:

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Total Medical Bills: _____

2. Name: _____ Phone: _____

Address:

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Total Medical Bills: _____

3. Name: _____ Phone: _____

Address:

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Total Medical Bills: _____

*Attach separate sheets if necessary.

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING PASSENGERS

WITNESSES:

1. Name: _____ Phone: _____

Address:

Relationship: _____

What did they see?

Would they be willing to testify in court? Yes No

2. Name: _____ Phone: _____

Address:

Relationship: _____

What did they see?

Would they be willing to testify in court? Yes No

3. Name: _____ Phone: _____

Address:

Relationship: _____

What did they see?

Would they be willing to testify in court? Yes No

DAMAGES

How have your injuries changed your lifestyle?

List the names of your spouse and children (if applicable).

Describe any pain and suffering that you've experienced:

How has it affected:

Your relationships? _____

Sports? _____

Job Duties? _____

Household chores? _____

Motor Vehicle Accidents Only

Year: _____ Make: _____ Model: _____

Where was the damage to your vehicle? _____

Was your vehicle repaired? Yes No

If yes, where was the repair performed? _____

What was the monetary amount of damages to your vehicle? \$ _____

Please provide any repair receipts or damage estimates.

If an individual referred you, please provide their name and address so that we can thank them.

OFFICE USE ONLY

SOL: _____

File No. _____

If client has been served with pleadings, when is the response due? _____

Entered into Calendar? Yes No Initials _____

CONTINGENCY FEE: _____ %

Litigation Percentage _____ %