839 S. Beacon Street
Suite 311
San Pedro, CA 90731

Ph. (310) 514-1200
Fax (310) 514-1200
www.NaylorLaw.com

CLIENT INTERVIEW FORM

AUTO ACCIDENTS

Please fill out the following form to the best of your ability.

YOUR INFORMATION

First Name:____________________ MI:_____ Last Name:_____________________________

Address: ____

City: ______________________________ State: _____________ Zip:_________________

Drivers License #:_____________________ State: ______________________________

Date of Birth:_________________________ SSN: _______________________________

Email Address:_______________________ Phone (home):________________________

Phone (work): _______________________ Phone (cell): _________________________

Alternative Contact Info

Name:______________________________ Relationship:___________________________

Phone Number:______________________

Do You Speak English? ❑ Yes ❑ No

Do You Need a Translator? ❑ Yes ❑ No

REFERRAL SOURCE INFORMATION

How did you find us?

❑ Website
❑ Internet Search
❑ Yellow Pages
❑ Friend or Relative (see below)
❑ Another Lawyer (see below)
❑ Doctor or Medical Provider (see below)
❑ Other:

Please provide the following information about who referred you to us so we may thank them for their kind recommendation.

First Name:__________________________ Last Name:__________________________

Email Address:________________________ Phone Number:_______________________

INSURANCE INFORMATION

Your Auto Insurance

Auto Insurance Provider: ______________________________

City: ____________________ State: ____________ Zip: ____________

Phone Number: ____________________ Policy #: ____________________

Adjuster's Name: ____________________ Claim #: ____________________

Name the Policy is Under: ______________________________

Coverage Limits

❑ Uninsured Motorist: $ ____________ ❑ Medical: $ ____________

❑ Deductible: $ ____________ ❑ Collision: $ ____________

❑ Other: $ ____________

Your Medical Insurance

Insurance Provider: ______________________________

City: ____________________ State: ____________ Zip: ____________

Phone Number: ____________________ Policy #: ____________________

Name the Policy is Under: ______________________________

YOUR VEHICLE INFORMATION

Year: __________ Make: ____________________ Model: ____________

Color: ____________________ License Plate #: ____________________

Registered Owner: ______________________________

Damages: ______________________________

____

Current Location of Vehicle: ______________________________

Driver at Time of Accident: ______________________________

Passengers at Time of Accident: ______________________________

____

OTHER VEHICLE INFORMATION

If needed, additional Other Vehicle Information sheets can be downloaded:
www.NaylorLaw.com/Resource/Forms

Vehicle Information

Year: _____________ Make: _________________________ Model:_____________________

Color:____________________________ License Plate #: ________________________________

Registered Owner:____

Damages:____

____

Current Location of Vehicle:____

Driver at Time of Accident:____

Passengers at Time of Accident: ____

____

Insurance Information

Auto Insurance Provider: ____

City: _______________________________ State: ______________ Zip:_________________

Phone Number:__________________________ Policy #: ______________________________

Adjuster's Name:__________________________ Claim #: ______________________________

Name the Policy is Under: ____

Coverage Limits

- ❑ Uninsured Motorist: $ _______________
- ❑ Medical: $ _________________________
- ❑ Deductible: $ _______________________
- ❑ Collision: $ ________________________
- ❑ Other: $ ___________________________

ABOUT THE ACCIDENT

Date of Accident:___________________________ Time of Accident: ______________________

Day of Week:_________________________ Weather Conditions: _________________________

Address of Accident Location: ____

City: ________________________________ State: ______________ Zip:________________

Nearest Cross-Streets: ____

Your Vehicle Speed at Time of Accident: _______________ m.p.h.

Other Vehicle Speed at Time of Accident:_______________ m.p.h.

Posted Speed Limit:______________ m.p.h.

Where was nearest Speed Limit sign located?____

Please Describe the Accident and How it Occurred:

ACCIDENT REPORTING & DOCUMENTATION

Police Called? ❑ Yes (see below) ❑ No

By Whom? :____

Police Report Taken? ❑ Yes (see below) ❑ No

By Whom? :____

Were Cars Moved Before the Investigation? ❑ Yes (see below) ❑ No

By Whom? :____

Were Photographs Taken? ❑ Yes (see below) ❑ No

By Whom? :____

Any Witnesses? ❑ Yes (see next page) ❑ No

What Was Said, If Anything, At the Scene of the Accident?

By You:

By Passengers:

By Other Driver:

By Witnesses:

By Police:

WITNESS INFORMATION

If needed, additional Witness sheets can be downloaded: www.NaylorLaw.com/Resource/Forms

Witness #1

First Name: ______________________ Last Name: ______________________

Address: ____

Phone (home): ____________________ Phone (cell): ____________________

Email Address: ____

Can Testify To/About: ____

Witness #2

First Name: ______________________ Last Name: ______________________

Address: ____

Phone (home): ____________________ Phone (cell): ____________________

Email Address: ____

Can Testify To/About: ____

Witness #3

First Name: ______________________ Last Name: ______________________

Address: ____

Phone (home): ____________________ Phone (cell): ____________________

Email Address: ____

Can Testify To/About: ____

Witness #4

First Name: ______________________ Last Name: ______________________

Address: ____

Phone (home): ____________________ Phone (cell): ____________________

Email Address: ____

Can Testify To/About: ____

DESCRIPTION OF INJURIES

At the Accident Scene

Did the Fire Department Respond to the Scene? ❑ Yes ❑ No

Did an Ambulance Respond to the Scene? ❑ Yes ❑ No

Were You Transported to a Hospital? ❑ Yes (see below) ❑ No

Which Hospital?: ____

Who Was Your Treating Physician?: ____________________________

Have You Seen a Doctor Since the Accident? ❑ Yes ❑ No

Please List All Doctors, Hospitals or Clinics You've Sought Treatment From:

(1) Name:____

Address: ____

Phone: __________________________ Date Last Seen: ____________________________

(2) Name:____

Address: ____

Phone: __________________________ Date Last Seen: ____________________________

(3) Name:____

Address: ____

Phone: __________________________ Date Last Seen: ____________________________

(4) Name:____

Address: ____

Phone: __________________________ Date Last Seen: ____________________________

(5) Name:____

Address: ____

Phone: __________________________ Date Last Seen: ____________________________

DESCRIPTION OF INJURIES (continued)

Describe Your Injuries / Affected Body Parts:

What are Your Current Health Complaints?

Were Others Injured? ❑ Yes (see below) ❑ No

Describe Injuries to Others:

YOUR EMPLOYEMENT

Employer on Date of Accident:____

Address: ____

City: ____________________________ State: _____________ Zip:________________

Phone: _____________________________ Fax: ________________________________

Email Address: ____

Person to Contact (to verify employment/earnings): __________________________________

Employment / Earnings Information
As of date of injury.

Job Title: ____

Pay Rate: ___________________________ Per (week, month, year): ________________

Overtime Rate: ________________________ Per: __________________________________

Other Pay: ____

List Additional Employment Benefits Below (i.e. medical, pension, profit sharing, etc.)

Have You Lost Time from Work? ❑ Yes (see below) ❑ No

How Much? :____

PRE-INJURY / ACCIDENT INFORMATION

Factors affecting pre-injury / accident earning capacity

PRE-INJURY / ACCIENT INFORMATION (continued)

Have You Ever Been Involved in Prior Accident? ❑ Yes (see below) ❑ No

When?:____

Where?:____

Claim Filed? ❑ Yes ❑ No

Lawsuit Filed? ❑ Yes ❑ No

Attorney Hired? ❑ Yes (see below) ❑ No

Attorney Name:__________________________________

Disposition of Case: ❑ Pending ❑ Settled

Please Describe the Prior Accident / Injuries: