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CLIENT INTERVIEW FORM

CRUISE SHIP PASSENGERS

Interview Date:________________________ Interviewed By:______________________________

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

YOUR INFORMATION

First Name:_____________________ MI:_____ Last Name:______________________________

Address: ____

City: _______________________________ State: ______________ Zip:_________________

Date of Birth:__________________________ SSN: ________________________________

Marital Status: ❑ Married ❑ Single

Email Address:________________________ Phone (home):______________________

Phone (work): ________________________ Phone (cell): _________________________

Alternative Contact Info

Name:________________________________ Relationship:____________________________

Phone Number:________________________

REFERRAL SOURCE INFORMATION

How did you find us?

❑ Website
❑ Internet Search
❑ Yellow Pages
❑ Longshore Injury Hotline
❑ 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:________________________

THE CRUISE SHIP

Cruise Operator (i.e. Princess, Carnival, etc.): ___________________________________

Vessel Name: ______________________ Official Number: ____________________

Vessel Owner/Operator (if different than cruise operator): ___________________________

YOUR INSURANCE INFORMATION

Insurance Provider (Primary): ____

Address: ____

City: __________________________ State: ____________ Zip:_______________

Phone: _____________________________________

Insurance Claim #: ___________________ Prescription Plan: _____________________

Adjuster Name: ____

Phone: _____________________________________

Insurance Provider (Secondary): ____

Address: ____

City: __________________________ State: ____________ Zip:_______________

Phone: __________________________

Insurance Claim #: ___________________ Prescription Plan: _____________________

Adjuster Name: ____

Phone: _____________________________________

Medicare HIC No. (if applicable): ____

Has Medicare paid injury/accident-related bills? ❑ Yes ❑ No

Please list any other applicable insurance below (i.e. Travel Insurance, etc.)

YOUR CRUISE

Cruise Dates:____

Port of Call Departed From (i.e. Los Angeles, Miami): __________________________

Cost of Cruise: ____

Cruise Itinerary

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

Port: __________________________________

Arrival / Departure: ________________________

Port: __________________________________

Arrival / Departure: ________________________

Port: __________________________________

Arrival / Departure: ________________________

YOUR CRUISE *(continued)*

Passage Ticket Limitations

Notice of Claim Requirement? ❑ Yes ❑ No

Last Day to Give Notice: ____

Statute of Limitations? ❑ Yes ❑ No

Last Day to File Suit: ____

Venue Provisions? ❑ Yes ❑ No

Venue for Filing Suit: ____

Source for Passage Ticket Limitations Info Above: _____________________________

INJURY REPORTING & INVESTIGATION

Date of Injury: _____________________

Was the injury / accident reported? ❑ Yes (see below) ❑ No

How did you report the injury / accident? ❑ Written ❑ Oral

Who did you report the injury to?: ______________________________________

When was the injury / accident reported?: ____

Where was the injury / accident reported: ____

Did you provide a statement? ❑ Yes (see below) ❑ No

Where? ____________________________________

When? ____________________________________

To Whom? ____________________________________

How? ❑ Written ❑ Oral

Do you have a copy of the statement? ❑ Yes ❑ No

Was there an accident investigation that you are aware of? ❑ Yes (see below) ❑ No

What Investigation?______________________________

By Whom? ____________________________________

When? ____________________________________

Do you have a copy of the report? ❑ Yes ❑ No

Were there any films, videos or photographs taken? ❑ Yes (see below) ❑ No

Of What? ____________________________________

By Whom? ____________________________________

When? ____________________________________

Do you have copies? ❑ Yes ❑ No

Have you provided copies to your lawyer? ❑ Yes ❑ No

ABOUT THE INJURY / ACCIDENT

Facts about your injury / accident:

ABOUT THE INJURY / ACCIDENT *(continued)*

Facts about your injury / accident *(continued)*

Nature of Injury

(list all injuries, body parts affected and surgeries performed and/or recommended)

ABOUT THE INJURY / ACCIDENT *(continued)*

Medical Care

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

(#1) Office / Practice:________________________ Dr Name:____________________________

Address: ____

City: ______________________________ State: ______________ Zip:_________________

Phone: _______________________________ Fax: _________________________________

Date First Seen: _________________________ Date Last Seen: _______________________

Treatment Provided: ____

____

____

(#2) Office / Practice:________________________ Dr Name:____________________________

Address: ____

City: ______________________________ State: ______________ Zip:_________________

Phone: _______________________________ Fax: _________________________________

Date First Seen: _________________________ Date Last Seen: _______________________

Treatment Provided: ____

____

____

(#3) Office / Practice:________________________ Dr Name:____________________________

Address: ____

City: ______________________________ State: ______________ Zip:_________________

Phone: _______________________________ Fax: _________________________________

Date First Seen: _________________________ Date Last Seen: _______________________

Treatment Provided: ____

____

____

ABOUT THE INJURY / ACCIDENT *(continued)*

Theory of Liability: Negligence

Theory of Liability: Dangerous / Defective Conditions

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: ____

PERIOD(S) OF DISABILITY

Periods of disability from work or *usual activities*.

Temporary Total Dates: ______________________________

Temporary Partial* Dates: ______________________________
**Working with doctor's restrictions & with actual loss of earnings as a result.*

Permanent & Stationary Date: ______________________________

Permanent Work Restrictions, if any: ______________________________

____

Return to Work Date(s): ______________________________

YOUR EMPLOYEMENT

Provide the information below if loss of earnings/earning capacity is being claimed.

Employer Information

Employer (on date of injury): ______________________________

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: ______________________________

Base Pay Rate: ____________________ Per (week, month, year): __________

Overtime Rate: ____________________ Per: ____________________

Other Pay: ______________________________

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

YOUR EMPLOYEMENT (continued)

Post-Injury Income
Other than wages.

Source: ____

For What Period? ____________________________________

Amount:____

PRE-INJURY / ACCIDENT INFORMATION

Factors affecting pre-injury / accident earning capacity

Any change of employment/job in the year (past 52 weeks) before or any time after the injury / accident?
❑ Yes (see below) ❑ No

Please provide information about your change of employment / job

Any unusual time off work in the year (past 52 weeks) before or any time after the injury / accident?
❑ Yes (see below) ❑ No

Please provide information about your time of work

PRE-INJURY / ACCIENT INFORMATION (continued)

Please provide information about any other factors affecting your pre-injury / accident earning capacity.

PRIOR INJURIES

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

Work Related

(1) Date of Injury (DOI): ________________ Employer on DOI: ______________________

Nature of Injury: ____

____

DR Name: __________________________ DR Name: ____________________________

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _________________

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: ________________

Did you file a workers' compensation claim? ❑ Yes (see below) ❑ No

Attorney Name: ____

Case Status: ❑ Pending ❑ Settled Settlement Amount:___________________________

(2) Date of Injury (DOI): ________________ Employer on DOI: ______________________

Nature of Injury: ____

____

DR Name: __________________________ DR Name: ____________________________

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _________________

PRE INJURY/ACCIENT INFORMATION *(continued)*

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: ________________

Did you file a workers' compensation claim? ❑ Yes (see below) ❑ No

Attorney Name: ____

Case Status: ❑ Pending ❑ Settled Settlement Amount:____________________________

Non-Work Related

(1) Date of Injury: ____

Nature of Injury: ____

____

DR Name: ____________________________ DR Name: ______________________________

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: ________________

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: ________________

Did you file a claim or lawsuit? ❑ Yes (see below) ❑ No

Attorney Name: ____

Case Status: ❑ Pending ❑ Settled Settlement Amount:____________________________

(2) Date of Injury: ____

Nature of Injury: ____

____

DR Name: ____________________________ DR Name: ______________________________

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: ________________

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: ________________

Did you file a claim or lawsuit? ❑ Yes (see below) ❑ No

Attorney Name: ____

Case Status: ❑ Pending ❑ Settled Settlement Amount:____________________________

PRE INJURY/ACCIENT INFORMATION *(continued)*

Pre-Existing Conditions
(other than injuries listed above, including all chronic or serious physical or mental conditions)

(1) Nature of Condition: ____

____

DR Name: ____________________ DR Name: ____________________

Did your condition require surgery? ❑ Yes ❑ No If yes, date of surgery: __________

Did you lose time at work due to the condition? ❑ Yes ❑ No Time off work: __________

(2) Nature of Condition: ____

____

DR Name: ____________________ DR Name: ____________________

Did your condition require surgery? ❑ Yes ❑ No If yes, date of surgery: __________

Did you lose time at work due to the condition? ❑ Yes ❑ No Time off work: __________

(3) Nature of Condition: ____

____

DR Name: ____________________ DR Name: ____________________

Did your condition require surgery? ❑ Yes ❑ No If yes, date of surgery: __________

Did you lose time at work due to the condition? ❑ Yes ❑ No Time off work: __________

(4) Nature of Condition: ____

____

DR Name: ____________________ DR Name: ____________________

Did your condition require surgery? ❑ Yes ❑ No If yes, date of surgery: __________

Did you lose time at work due to the condition? ❑ Yes ❑ No Time off work: __________

DAMAGES

Damages Issues
(Identify any damages issues not described above)