LAW OFFICES OF
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CLIENT INTERVIEW FORM

GENERAL PERSONAL INJURY

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:_____

Drivers License #:_____ State: _____

Date of Birth:_____ SSN: _____

Marital Status: ❑ Married ❑ Single

Email Address:_____ Phone (home):_____

Phone (work): _____ Phone (cell): _____

Do You Speak English? ❑ Yes ❑ No Do You Need a Translator? ❑ Yes ❑ No

Alternative Contact Info

Name:_____ Relationship:_____

Phone Number:_____

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

About Other Party (Defendant)

Name: _____

Other Party is an: ❑ Individual ❑ Partnership ❑Corporation

Address: _____

City: _____ State: _____ Zip:_____

Phone Number:_____ Email: _____

Defendant's Insurance

Insurance Provider: _____

Address: _____

City: _____ State: _____ Zip:_____

Adjuster's Name:_____ Phone: _____

Fax :_____ Email: _____

STATUTE OF LIMITATIONS / JURISDICTION / VENUE

To be completed by attorney.

Is there a written notice and/or administrative claim requirement? ❑ Yes ❑ No

Last day to give notice / file claim: _____

Applicable statute of limitations: _____

Last day to file suit: _____

Jurisdiction / Venue: _____

Venue for filing suit: _____

Source of information for above: _____

Other information concerning time limits, jurisdiction or venue:

ABOUT THE ACCIDENT

Date of Injury:_____ Time: _____

Place of Accident:_____

Description of Accident:

ACCIDENT REPORTING / INVESTIGATION

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

Where?_____

When?_____

To Whom?_____

How? ❑ Written ❑ Oral

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

Where?_____

When?_____

To Whom?_____

How? ❑ Written ❑ Oral

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

What investigation?_____

By Whom?_____

When?_____

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

What was filmed videod or photographed?_____

_____

By Whom?_____

When?_____

Do you have any such documents, films, photographs, etc? ❑ Yes (see below) ❑ No

Have copies been provided to the law firm? ❑ Yes ❑ No

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: _____

THEORY OF LIABILITY

NATURE OF INJURY

Your Injuries
Describe Your Injuries / Affected Body Parts / Surgeries Performed and or Recommended

MEDICAL CARE

List each health care provider in the order seen and describe the general nature of treatment. *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: _____

_____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

(#2) Office / Practice:_____ Dr Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Date First Seen: _____ Date Last Seen: _____

Treatment Provided: _____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

(#3) Office / Practice:_____ Dr Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Date First Seen: _____ Date Last Seen: _____

Treatment Provided: _____

_____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

MEDICAL INSURANCE

Primary Insurance: _____

Policy #: _____

Address: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone: _____

Fax : _____ Email: _____

Secondary Insurance: _____

Policy #: _____

Address: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone: _____

Fax : _____ Email: _____

Prescription Plan: _____

Is prospective new client Medicare eligible? ❑ Yes ❑ No

Medicare HIC #: _____

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

Other applicable insurance information (trip insurance, disability, etc.)

DISABILITY

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 Partial Dates: _____

Permanent & Stationary Date: _____

Permanent Work Restrictions, if any: _____

_____

Fit for Duty Date: _____

Return to Work/Usual Activities Date(s): _____

YOUR EMPLOYEMENT*

**If loss of earnings / earning capacity is being claimed.*

Employer on Date of Accident: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Phone: _____ Fax: _____

Email Address: _____

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

Any change of employment/job in the 2 years before or any time after the accident?
❑ Yes (see below) ❑ No

Describe changes:

Any unusual time off work in the 2 years before or any time after the accident?
❑ Yes (see below) ❑ No

Describe time off:

Other:

PRIOR INJURIES / CLAIMS

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 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: _____

MEDICAL HISTORY

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: _____

OTHER DAMAGES

Identify any damages or issues not described above:

INITIAL PLAN

To be completed by attorney.