BURKE BLUE HUTCHISON WALTERS & SMITH, P.A.

CONFIDENTIAL CLIENT INFORMATION FORM

This questionnaire is a confidential questionnaire for the use of our office only in preparing your claim for personal injuries. The information you furnish us will not be released and will be held strictly confidential. When your claim has been concluded, we will return this questionnaire to you if you wish. Please answer every question fully and accurately because, as your attorneys, we must know all about you and your case. One surprise because of an incorrect or incomplete answer could cause you to lose your case. All of the questions are important even though they may not appear to have anything to do with your case.

CASE INFORMATION

YOUR NAME:_____

DATE OF ACCIDENT:_____

YOUR INSURANCE COMPANY:_____

NAME OF OTHER PERSON:_____

OTHER PERSON'S INSURANCE COMPANY:_____

PLAINTIFF INFORMATION

1. What is your full name?_____

2. Birthplace:_____

3. Social Security No.:_____

4. Phone No.:_____ (work) _____ (home)

5. Address:_____

6. Birth Date:_____

7. Mother's Name:_____

8. Father's Name:_____

9. Marital status:
Married ___ Single ___ Divorced ___
Separated ___ Widow ___ Widower ___

10. If divorced, date and place:_____

11. If spouse deceased, date of death:_____

12. Names, ages, and addresses of all those (including children) who are dependent upon you for support, and your relationship to each:

Name	Address	Age	Relationship

WORK BACKGROUND

1. Present job:_____

2. Name and address of employer:_____
_____

3. Present job title and duties:_____
_____

4. How long have you worked at this job?_____

5. Work Phone:_____

6. Your present pay:_____

7. If you were not working for this employer at the time of your accident, state the following:

   a. Name of employer:_____

   b. Address of employer:_____
   _____

   c. Job title and type of work:_____
   _____

   d. Rate of pay:_____

   e. Hours per week regularly worked:_____

   f. First began working for this employer:_____

   g. When left this employer:_____

   h. Why left this employer:_____

8. What did you earn in the year before your accident took place? _____

9. List prior employment for past five years:

Name	Dates Employed	Job Description

10. Spouse:

    Name and address of employer:_____

    Wages:_____ Average annual income:_____

    How long employed?_____

    Spouse's prior employment: _____

DAMAGES FROM ACCIDENT

The amount of recovery made in this case will be affected by the damages or expenses incurred as a result of your accident. It is important that you fully list all information regarding your injuries and your expenses as a result of this accident.

1. State, in full detail, all injuries you received as a result of this accident:_____

2. State your present physical condition - scars, deformities, headaches, pains, etc., due to injuries received in this accident:_____

3. Have you missed any time from work as a result of your injury?_____

   If so, list the inclusive dates you were unable to work:

   From:_____ To:_____
   From:_____ To:_____
   From:_____ To:_____

4. Did you lose wages for the periods of time missed from work due to this accident?_____

   If so, explain:_____

5. Have you had any increases or decreases in your pay since the accident?_____

   If so, explain:_____

6. List all hospitals in which you were examined or treated, or to which you were admitted as a patient as a result of the injuries sustained in the accident, the dates, and the total costs:

a. Hospital:_____
Address:_____
From:_____ To:_____
Total costs:_____

b. Hospital:_____
Address:_____
From:_____ To:_____
Total costs:_____

c. Hospital:_____
Address:_____
From:_____ To:_____
Total costs:_____

7. List the full name, address, and telephone number of each physician or surgeon who has examined or treated you for your injuries as a result of the accident:

a. Doctor's name:_____
Address:_____
Phone number:_____
Type of treatment:_____
_____

b. Doctor's name:_____
Address:_____
Phone number:_____
Type of treatment:_____
_____

c. Doctor's name:_____
Address:_____
Phone number:_____
Type of treatment:_____
_____

Continue on the back if needed

8. Have you used any of the following in connection with treatment: If so, give the dates you used each.

Back or neck brace?_____
Crutches?_____

Traction?_____
Physiotherapy?_____
Other?_____

9. List here all of your usual activities which you have not been able to perform, or can only perform with difficulty, since the accident, such as climbing stairs, ironing, cutting grass, dancing, lifting children, etc.:_____
_____
_____
_____

10. Time lost from school:_____

11. Period you were confined to your house:_____

12. Please summarize your out-of-pocket expenses, and if you have not previously given us the name and address, indicate to whom they are owed, as well as the amounts, and whether they have been paid.

	Amount	Paid
Physicians & surgeons:_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Ambulance:_____	_____	_____
_____	_____	_____
_____	_____	_____
Hospitals:_____	_____	_____
_____	_____	_____
_____	_____	_____
Nurses:_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Drugs:_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Crutches, braces, etc.:		
X-rays:		
Domestic help:		
Auto repair:		
Car rental:		
Lost wages:		
Other:		
TOTAL:		

PAST MEDICAL HISTORY

The amount of recovery made in this case may be affected by your past medical history and the medical treatment you received prior to your accident. It is important that you fully list all information regarding your medical treatment and condition.

1. List the full name, address, and telephone number of each physician, surgeon, medical clinic or hospital who has examined or treated you for any medical condition in the past ten (10) years:

   a. Doctor's name:_____
   Address:_____
   Phone number:_____
   Condition/type of treatment:_____

   b. Doctor's name:_____
   Address:_____
   Phone number:_____
   Condition/type of treatment:_____

   c. Doctor's name:_____
   Address:_____
   Phone number:_____
   Condition/type of treatment:_____

Continue on the back if needed

2. Have you ever been given a disability rating or been declared to have a permanent injury by any medical provider? Yes/No_____ If so, please provide the following:

   a. Doctor's name:_____
   Address:_____
   Phone number:_____
   Condition/date of disability:_____
   b. Doctor's name:_____
   Address:_____
   Phone number:_____
   Condition/date of disability:_____

3. Do you suffer from any long-standing or ongoing medical conditions which require regular monitoring, check-ups or medication (i.e. diabetes, high blood pressure, etc.)? If so, please describe the condition, how monitored and name of doctor treated by:_____
   _____

CONCLUSION

In completing this questionnaire, have you thought of any information which we have not asked which may be of some assistance to us in serving you? If so, please state it here no matter how silly, trivial, or embarrassing it may seem.

_____

_____

_____

_____

_____

_____

Dated this ____ day of _____, 2017.

I have read the above statement
and the statements contained
therein are true and correct.

_____