

CLIENT INTAKE FORM

1. **Client(s):**

Background:

Name: _____

Address: _____

Date of birth: _____

Social Security Number: _____

Marital Status: _____

Name of Spouse (if applicable): _____

Name(s) of Child(ren): _____

Telephone Number (home): _____

Telephone Number (work): _____

Telephone Number (cell): _____

Email address: _____

Employer: _____

Employer's Address: _____

Position: _____

Duties: _____

Salary (present): _____

Salary (last five years): _____

2. **Incident/Accident:**

Date: _____

Time: _____

Place: _____

Circumstances/How did the injury occur: _____

Witnesses: _____

Work Related? (yes/no) Explain why or why not: _____

Was law enforcement called? By Whom? What law enforcement agency came to scene? _____

Was ambulance personnel called? By Whom? Which ambulance personnel came? _____

Describe details of the manner in which you reported the injury: _____

3. **Injuries:**

Describe each body part that was injured and in what way: _____

Describe how each injury manifested itself. What did it initially feel like? Was it made worse by time or better with the passing of time? In what way?: _____

Diagnosis: _____

Prognosis: _____

Describe all prior Medical History/Problems/Pre-existing Injuries to the same areas as injured: _____

4. **List all physicians you have seen thus far:**

Name: _____

Address: _____

Dates of treatment: _____

What physician told you about your condition: _____

Name: _____

Address: _____

Dates of treatment: _____

What physician told you about your condition: _____

Name: _____

Address: _____

Dates of treatment: _____

What physician told you about your condition: _____

Name: _____

Address: _____

Dates of treatment: _____

What physician told you about your condition: _____

5. **List as much information as you know about the at-fault driver and his or her insurance company:**

At-Fault Driver's name: _____

At-Fault Driver's address: _____

At-Fault Driver's phone: _____

Insurance carrier's name: _____

Insurance carrier's address: _____

Insurance carrier's phone: _____

Insurance carrier's fax: _____

Name of adjustor assigned: _____

Address of adjustor assigned: _____

Phone of adjustor assigned: _____

Fax of adjustor assigned: _____

Email of adjustor assigned: _____

Assigned claim number: _____

6. **List as much information as you can about your own insurance company:**

Your insurance carrier's name: _____

Your insurance carrier's address: _____

Your insurance carrier's phone: _____

Your Insurance carrier's fax: _____

Name of adjustor assigned: _____

Address of adjustor assigned: _____

Phone of adjustor assigned: _____

Fax of adjustor assigned: _____

Email of adjustor assigned: _____

Assigned claim number: _____