

Client Intake Form
Slip and Fall

Today's Date: _____

First Name: _____ Middle Name _____ Last Name: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Date of Birth: _____ SSN: _____

Married ___ Single ___ Divorced ___ Widowed ___ Minor ___

Spouse's Name: _____

Spouse's Date of Birth: _____ Spouse's SSN: _____

ACCIDENT DETAILS

Date of Accident: _____ Time of Accident: _____

What was the location and address of the accident? _____

City: _____ State: _____

Was an incident report taken due to this accident? Yes ___ No ___ Incident No.: _____

How would you describe the property where this accident occurred? (commercial property, private property) _____

What are the names of any and all adverse parties where you fell? _____

Describe in detail how this accident happened: _____

Please draw a diagram of the accident scene:

Did you talk to any witnesses at the scene of the accident? Yes _____ No _____

If yes, please list any and all witnesses:

Name: _____ Relation to you: _____ Address: _____ Phone #: _____

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Name: _____ Relation to you: _____ Address: _____ Phone #: _____

Do you have any pictures of the location where this accident occurred? Yes _____ No _____

Do you know the name of the insurance carrier of the owners/tenants where this accident occurred?

Yes _____ No _____ If yes, please list the name(s) of the insurance company: _____

Did you report this accident to any insurance agent or company? Yes _____ No _____

Did you give a statement to any insurance company? Yes _____ No _____

If yes, when and what insurance company? _____

Please list any claim numbers you have been given by any insurance carrier for this accident _____

INJURIES AND TREATMENT

What injuries did you receive from this accident? _____

Did you go to the hospital due to your injuries? Yes _____ No _____

If yes, were you transported from the scene via ambulance? Yes _____ No _____

Provide the name of ambulance company: _____

Provide the name of the hospital: _____

How long did you stay at the hospital? _____

What kind of treatment did you receive from the hospital? _____

Did you have x-rays, MRI or other diagnostic tests? Yes _____ No _____

If yes, explain what type and what results? _____

Did you receive any broken bones or scarring from this accident? Yes _____ No _____

If so, explain: _____

Have you taken any photographs of your accident injuries? Yes _____ No _____

Please list all other providers you have treated with or are currently treating with as a result of this accident (specialist, chiropractor, primary care physician, physical therapy, rehabilitation)?

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

What is the approximate amount of your medical bills? \$ _____

If yes, did you take any photographs of your injuries? Yes _____ No _____

Did they give you an estimate cost for such future revision? _____

Do you have health insurance? Yes _____ No _____ What carrier: _____

Have you had any other injuries or medical treatment before this accident? Yes _____ No _____

Are the injuries/medical treatment within the past five years? Yes _____ No _____

If yes, please list year of previous accident, type of accident and type of injuries/medical treatment: _____

Were you taking any medication on the date of the accident? Yes _____ No _____

If yes, what medications? _____

Have you had any other injuries after this accident? Yes _____ No _____

If yes, please describe: _____

LOST INCOME OR WAGES

Did you miss work time as a result of this accident? Yes _____ No _____ How much time? _____

Your employer/occupation: _____

Address: _____

Name of supervisor and telephone number: _____

ADDITIONAL INFORMATION

Have you or are you filing for bankruptcy? Yes: _____ No: _____

Are you paying child support? Yes: _____ No: _____

Do you currently or have you had another attorney in this matter? Yes _____ No _____

If yes, who is/was your other attorney? _____

Emergency contact information:

Please provide two names and phone numbers of close relatives that do not live with you:

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

How did you hear about us? _____

I _____ understand that this is a **free consultation** about my accident and that I am not represented until I speak with the attorney who agrees to accept my case and I sign a fee agreement. I understand that my case may or may not be accepted by the attorney.

Sign Name: _____ Date: _____

Print Name: _____ Date: _____