Internal Office Use
Staff member initials for interview: ____________ **Date of Incident** : ______________

Statute of Limitations: ______________ **Potential Defendants:** ______________________

____

CLIENT INTAKE FORM

Please take the time to answer the questions below as accurately and as fully as possible. This information may be relied upon by our firm in representing you. You can trust that this information will be used strictly for the purpose of representing you. Thank you.

Strom & Associates, Ltd.

Today's Date: ______/______/____________

How were you referred to our office?: ________________________________

GENERAL BACKGROUND INFORMATION

Name: ____

Home Address: ____

____

Date of Birth: ______/______/______

Social Security no.: __________________________

Home Phone: __________________________

Mobile Phone: __________________________

Work Phone: __________________________

Email: __________________________

Marital Status: __________________________

Spouse's Name: __________________________

Maiden name: __________________________

Military Service Branch:____

Membership:

Social Organizations: ____________________

Religious Organizations: ____________________

Professional Organizations: ____________________
(e.g. unions, trades, etc.)

Family Doctor: ____________________

Current Employer:

Name: ____________________

Address: ____________________

____

Supervisor: ____________________

Title/position: ____________________

Wage rate:

Hourly: ____________

Salary: ____________

Overtime rate: ____________

Previous Employer(s) up to 5 years preceding today's date:

1)

Employer Name: ____________________

Address: ____________________

____

Supervisor: ____________________

Title/position: ____________________

Wage rate:

Hourly: ____________

Salary: ____________

2)

Employer Name: ______________________________

Address: ______________________________

____

Supervisor: ______________________________

Title/position: ______________________________

Wage rate:

Hourly: ______________

Salary: ______________

Overtime rate: ______________

INFORMATION REGARDING THIS MATTER

Date claim arose/
Date of injury: ____/____/______

Where did it occur?:

Street or Address: ______________________________

____

Approximate time: ______________________________

What happened?: ______________________________

____

____

____

____

____

____

**Please continue next page, if necessary

**What happened?: ______________________________

____

____

____

Witnesses:

1) Name: ______________________________

Address:______________________________

Telephone: ______________________________

2) Name: ______________________________

Address:______________________________

Telephone: ______________________________

3) Name: ______________________________

Address:______________________________

Telephone: ______________________________

Emergency personnel at scene:

Police: City: ______________________________

State: ______________________________

Police report no.: ______________________________

Ambulance: City: ______________________________

Fire Dept.: City: ______________________________

List all persons you believe to be at fault for your injuries:

1) Name: ______________________________

Address:______________________________

2) Name: ______________________________

Address:______________________________

3) Name: ______________________________

Please list all vehicles involved and provide following information:

1) Year, make & model: ______________________________

Color: ______________________________

Driver: ______________________________

Owner: ______________________________

Passenger(s): ______________________________

Insurance Company: ______________________________

Type of Damage: ______________________________

2) Year, make & model: ______________________________

Color: ______________________________

Driver: ______________________________

Owner: ______________________________

Passenger(s): ______________________________

Insurance Company: ______________________________

Type of Damage: ______________________________

3) Year, make & model: ______________________________

Color: ______________________________

Driver: ______________________________

Owner: ______________________________

Passenger(s): ______________________________

Insurance Company: ______________________________

Type of Damage: ______________________________

Did this occur on property? If Yes,

Owner(s) name: ______________________________

Address of property: ______________________________

Homeowner's insurance: ______________________________

Are there photographs of…

Injuries, if yes who has them: ______________________________

Property damage, if yes who has them: ______________________________

Scene of accident, if yes who has them: ______________________________

Have you communicated with anyone regarding this matter? If yes,

1) Name: ______________________________

Company: ______________________________

Was there a recording?: ______________________________

When?: ______________________________

2) Name: ______________________________

Company: ______________________________

Was there a recording?: ______________________________

When?: ______________________________

3) Name: ______________________________

Company: ______________________________

Was there a recording?: ______________________________

INFORMATION REGARDING YOUR INJURIES

How were you injured as a result of the incident?

Body part affected: & How is that part injured and what are you complaints of pain or discomfort:

____________________ ____

____________________ ____

____________________ ____

____________________ ____

____________________ ____

____________________ ____

Are you claiming any emotional or psychological injury? If yes, please describe: ____________________

____

____

Were you taken away by ambulance? ______________________________

Please state in order of date what doctor, facility and hospital have you seen for your injuries:

1) Doctor/Hospital: ____

Address: ____

Date of visit(s): ______/______/____________

What was done for you?:____

____

What tests were done?: ____

____

Medicine: ____

2) Doctor/Hospital: ____________________

Address: ____________________

Date of visit(s): ____/____/________

What was done for you?: ____________________

____

What tests were done?: ____________________

____

Medicine: ____________________

3) Doctor/Hospital: ____________________

Address: ____________________

Date of visit(s): ____/____/________

What was done for you?: ____________________

____

What tests were done?: ____________________

____

4) Doctor/Hospital: ____________________

Address: ____________________

Date of visit(s): ____/____/________

What was done for you?: ____________________

____

What tests were done?: ____________________

____

Medicine: ____________________

Do you have any appointments at this time for further medical care? If yes, please state:

1) Doctor/Hospital: ______________________________

Address: ______________________________

Date of appointment(s): ____/____/________

Type of medical care?: ______________________________

____

2) Doctor/Hospital: ______________________________

Address: ______________________________

Date of appointment(s): ____/____/________

Type of medical care?: ______________________________

____

3) Doctor/Hospital: ______________________________

Address: ______________________________

Date of appointment(s): ____/____/________

Type of medical care?: ______________________________

____

Do you have medical insurance? If yes, what type?

□ Employer insurance? Name of company: ____________________

□ ERISA plan? Name of company: ____________________

□ Union Health & Welfare plan? Name of company: ____________________

□ Military? Name of military branch: ____________________

Who is named on the plan?

□ You?

□ Spouse?

□ Family member?

Have you ever injured these same parts of your body previously or have any condition preceding this incident ? If yes, please state:

1) Part of Body: ______________________

What date of injury or date the condition was diagnosed: ______________________

____

How did it occur: ______________________

Type of medical care you received: ______________________

Doctor and hospitals: ______________________

Last doctor or hospital visit for treatment & date: ______________________

2) Part of Body: ______________________

What date of injury or date the condition was diagnosed: ______________________

____

How did it occur: ______________________

Type of medical care you received: ______________________

Doctor and hospitals: ______________________

Last doctor or hospital visit for treatment & date: ______________________

3) Part of Body: ______________________

What date of injury or date the condition was diagnosed: ______________________

____

How did it occur: ______________________

Type of medical care you received: ______________________

Doctor and hospitals: ______________________

Last doctor or hospital visit for treatment & date: ______________________

LITIGATION BACKGROUND INFORMATION

Please provide us with the following information for each and every lawsuit, bankruptcy, insurance claim, workers' compensation claim, bodily injury claim or work-related injury claim in which you have ever been involved.

1)

Type of claim: ____________________

What happened?: ____________________

____

____

Date claim arose/
Date of injury: ____________________

Was a lawsuit filed?: __________, Where: ____________________

Who was plaintiff?: ____________________

Who was defendant?: ____________________

Attorney(s): ____________________

Were you injured?: ____________________

Body parts injured: ____________________

____

Hospital & doctors: ____________________

____

____

____

When & How was claim resolved:

____

2)

Type of claim: ______________________________

What happened?: ______________________________

____

____

Date claim arose/
Date of injury: ______________

Was a lawsuit filed?: __________, Where: ______________________

Who was plaintiff?: ______________________

Who was defendant?: ______________________

Attorney(s): ______________________

Were you injured?: ______________________

Body parts injured: ______________________________

____

Hospital & doctors: ______________________________

____

____

____

When & How was claim resolved:

____

3)

Type of claim: ______________________________

What happened?: ______________________________

____

____

Date claim arose/
Date of injury: ____________________________

Was a lawsuit filed?: ______________, Where: ____

Who was plaintiff?: ____

Who was defendant?: ____

Attorney(s): ____

Were you injured?: ____

Body parts injured: ____

____

Hospital & doctors: ____

____

____

____

When & How was claim resolved:

____

● END ●