Lawyers toGo
A Professional Limited Company

PERSONAL INJURY INTAKE SHEET

Date:_____ How Did You Hear About Us:_____

Client Information

Name:_____	Home #:_____ Cell #:_____
Spouse:_____	Work #:_____ Other:_____
Address:_____	Email:_____
City:_____ State:_____ Zip:_____	Other:_____
Date of Birth:_____ SS#:_____	_____

Accident Information

Date:_____ SOL:_____	# Vehicles Involved:____ Pictures (Y/N):_____
Street:_____	Job-Related (Y/N):_____Pictures:_____
City:_____County:_____	Description / Conversation at the Scene:_____
Police Called / Accident Report:_____	_____
Citations Issued:_____	_____

Client Insurance

Health Insurance:_____	Auto Insurance:_____
Address:_____	Address:_____
Phone Number:_____	Phone Number:_____
Contact Name:_____	Contact Name:_____
Policy #:_____ERISA(Y/N):_____	Policy #:_____ Claim #:_____
Other Insurance:_____	UM:_____ MedPay:_____

Property Damage (Y/N):_____ **Paid by Whom:?_____**

Car Make:_____Year:_____	Body Shop / Salvage:_____
Purchase Price:_____ Mileage:_____	Est. Damage:_____ Wrecker:_____
Lienholder:_____ Lien $:_____	Deductible Amount:_____ Need Rental (Y/N):_____
Est. FMV:_____ Owner:_____	Damage Description:_____

Defendant #1

Name:_____	Insurance:_____
Address:_____	Prop Adjuster:_____
City:_____ State:_____ Zip:_____	PI Adjuster:_____
Driver / Passenger (D/P):____ DL#:_____	Limits:_____ Med Pay:_____
Car Make:_____ Owner (Y/N):_____	Other:_____

Defendant #2

Name:_____	Insurance:_____
Address:_____	Prop Adjuster:_____
City:_____ State:_____ Zip:_____	PI Adjuster:_____
Driver / Passenger (D/P):____ DL#:_____	Limits:_____ Med Pay:_____
Car Make:_____ Owner (Y/N):_____	Other:_____

Employment Information

Employer:_____	Wages/Salary:_____ Hrs. Lost:_____
Address:_____	Days Missed Due to Doctor Visits:_____
Title/Position:_____	Other Lost Opportunities / Financial:_____
Supervisor:_____	_____

Other Information

Injuries:_____

_____

_____

Witness #1:_____Witness # 2_____

Prior Accidents:_____

Prior Injuries:_____

_____

Other:_____

_____

NOTES

Medical: Treating Physician / Hospital / Clinic

Name:__________________________	Treatment Description:____________	RX:____________________________
Address:________________________	______________________________	______________________________
Phone #:________________________	______________________________	Amount of Treatment:$__________
Position:________________________	______________________________	Bills & Records Provided (Y/N):____
X Ray / MRI / CT:_______________	Treatment Finished:______________	Order? (Y/N/Wait):______________

Medical: Treating Physician / Hospital / Clinic

Name:__________________________	Treatment Description:____________	RX:____________________________
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Phone #:________________________	______________________________	Amount of Treatment:$__________
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