

Confidential Client Personal Injury Questionnaire

INFORMATION FOR YOUR INITIAL CONSULTATION

FAMILY & EMPLOYMENT BACKGROUND

Client's Date of Birth _____

Age at Time of Collision _____

Social Security # _____

California Driver's License # _____

Any Driving Limitations _____

Marital Status, Date of Marriage _____

Number of Children _____

Age(s) of Children _____

Occupation / Employment _____

Length of Occupation / Employment _____

Dates Started and/or Stopped _____

If you need more room to fully describe any requested information, feel free to fill out additional sheets of paper. Please be as detailed and accurate as possible and completely honest — the better information we have, the better we can represent your case.

FACTS OF THE ACCIDENT

Date _____

Place _____

Time of Day _____

Weather Conditions _____

Road Conditions _____

Client's Vehicle – Make and Model _____

Defendant's Vehicle – Make and Model _____

Origination of Client's trip _____

Intended Destination of Client's trip _____

FACTS OF THE ACCIDENT (CONTINUED)

Client's Safety Equipment *(Please check those that apply.)*

Seatbelt on? Yes _____ No _____ Securely fastened? Yes _____ No _____

If no, explain: _____

Shoulder Harness properly adjusted? Yes _____ No _____

If no, explain: _____

Head Rest? Yes _____ No _____ How was it adjusted? _____

Client Alone or with Passengers _____

Defendant Alone or with Passengers _____

Copy of Police Report Attached? Yes _____ No _____

Independent Witness Declarations *(If available.)*

Witness Name _____ Contact Number (_____) _____ - _____

Witness Name _____ Contact Number (_____) _____ - _____

Witness Name _____ Contact Number (_____) _____ - _____

Witness Name _____ Contact Number (_____) _____ - _____

Please attach copy of Police Report or additional contact information, if applicable.

Property Damage to Involved Vehicles

_____ Major _____

_____ Moderate _____

_____ Minor _____

Vehicle repair estimates attached? Yes _____ No _____

(Please attach copies of repair estimates, if available.)

Client's Vehicle _____ Totaled _____ Repaired _____ In Original After-Crash Condition

Client's vehicle towed from scene of accident? Yes _____ No _____

Details _____

Was client's car seat broken or damaged? Yes _____ No _____

Details _____

Photographs of property damage attached? Yes _____ No _____

If at all possible, include photos taken at the scene of the accident. If you were not able to do that, it is still very helpful to see photos of the vehicle and other property before any repairs or replacements have been made. The more photos showing every aspect of the damage (views from different sides, detail shots), the better chance we have of recovery.

CLIENT'S RELEVANT PRIOR MEDICAL HISTORY

Nature of Client's Injuries _____

Complaints of Pain at Scene of Accident _____

Objective Signs of Injuries (bruises, scratches, bleeding) _____

Photos of injuries or treatment attached? Yes _____ No _____

Describe Initial Treatment _____

WAGE LOSS CLAIM

Copy of doctor's instructions to be off work attached? Yes _____ No _____

If no, please describe (*reason, estimated length of time*). _____

and provide contact information

Doctor's Name _____

Doctor's Address _____

Doctor's Phone (_____) _____ - _____

Days and Hours Off Work _____

Rate of Pay _____

Employment Verification/Wage Loss Verification:

Company Name _____

Company Address _____

Contact Person _____

Company Phone (_____) _____ - _____

Estimated Wages Lost _____

Miscellaneous Damaged Items _____

Car Rental Expenses _____

Cab Expenses _____

Collision Deductible _____

Miscellaneous Property Damage _____

PROOF OF AUTOMOBILE INSURANCE

Insured? Yes _____ No _____

Copy of Auto Insurance (*Declaration Page of policy covering the time of accident*) attached?

Yes _____ No _____

Client's Car Insurance Company _____

Policy Number _____

Agent's Name _____

Agent's Address _____

Agent's Phone (_____) _____ - _____

OTHER INSURANCE POLICIES IN FORCE
AT THE TIME OF THE ACCIDENT

Client's Health Insurance Company _____

Policy Number _____

IMPORTANT: Please attach a copy of health insurance card (front and back of card).

Other insurance policies that might apply: (*Medi-Care, Medi-Cal, Disability, Worker's Compensation, etc.*)

If you have any questions about filling out this form, please call 805-642-6405.

FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE, AND TAKE IT WITH
YOU TO YOUR INITIAL CONSULTATION WITH:

LAW OFFICES OF

Daniel A. Higson

1835 Knoll Drive
Ventura, Ca 93003
805-642-6405

See our website for driving directions:
www.venturatty.com