***** CLIENT QUESTIONNAIRE - AUTO ACCIDENT *****
Hillsboro Law Group PC

Your full legal name:	

THE ACCIDENT	
Date of accident:	
Approximate time of accident:	
Location of accident: (include street, closest intersection(s) if known)	
Speed of your vehicle at moment of impact?:	
Speed of vehicle that caused accident?	
Name of person that caused the accident:	
When the accident occurred you were a (driver, passenger, pedestrian, etc.)	
Other people involved in the accident? (include names, phone numbers, and a brief description of how the person was involved in the accident. Attach separate sheets if necessary.)	
Describe any other facts you believe are important regarding the accident: (attach separate sheets if necessary)	
Was a DMV Accident Report filed?	
If yes, do you have copy of the DMV Accident Report?	
Were the police called to the accident?	
Did an ambulance come to the scene of the accident?	
Did the Fire Department come to the scene of the accident?	

INSURANCE INFO	
Name of <u>your</u> insurance company:	
Address (line 1):	

Address (line 2):	
Claim #:	
Adjuster assigned to claim:	
Name of liable insurance company:	
Address (line 1):	
Address (line 2):	
Claim #:	
Adjuster assigned to claim:	
Who has been paying for your medical treatment? (describe)	

LOST WAGES FROM ACCIDENT		
Did you miss any work because of the accident?		
If so, can you provide documentation to show missed work?		
Begin Date	End Date	Pay Rate

INJURIES FROM CURRENT ACCIDENT			
Describe the areas of your body injured in the accident: (left shoulder, right hand, lower back, etc.)			
Please put an "X" in the appropriate boxes below to explain how the accident has affected you:			
Description of Symptom	I have never experienced this because of the accident:	I initially felt this after the accident, but no longer experience it:	I continue to experience this as a result of the accident:

Pain			
Swelling			
Visible bruising			
Fracture			
Decreased range of motion			
Decreased strength			
Decreased ability to perform activities of daily living			
Muscle spasms			
Inability to work			
Difficulty sleeping			

MEDICAL TREATMENT FOR INJURIES FROM ACCIDENT	
In chronological order if possible, please list all physicians, surgeons, physical therapists, psychologists, and pain management care providers you have seen for your injury/injuries. If you are uncertain of an exact date or address, write "?". (attach additional sheets if needed)	
Name of 1st treatment provider:	
Address (line 1):	
Address (line 2):	
Nature of treatment: (please describe briefly)	
Date of first treatment:	
Date of last treatment:	
Name of 2nd treatment provider:	
Address (line 1):	
Address (line 2):	
Nature of treatment: (please describe briefly)	
Date of first treatment:	
Date of last treatment:	
Name of 3rd treatment provider:	

Address (line 1):	
Address (line 2):	
Nature of treatment: (please describe briefly)	
Date of first treatment:	
Date of last treatment:	
Name of 4th treatment provider:	
Address (line 1):	
Address (line 2):	
Nature of treatment: (please describe briefly)	
Date of first treatment:	
Date of last treatment:	

PRIOR ACCIDENTS, INJURIES & LAWSUITS	
Prior accidents, injuries & lawsuits: (briefly describe all, even if minor)	

WORKERS' COMP INFO	
Were you working when the accident occurred?	
Have you made a claim for Workers' Compensation for this injury?	
Are you receiving payments at present?	

VEHICLE INFORMATION	
Year / make / model of your vehicle:	
As a result of the accident, your vehicle was: (totalled, repaired, not damaged, etc.)	
Condition of vehicle prior to accident: (excellent, good, fair, poor)	
# of miles on your vehicle at time of accident:	