

**PERSONAL INJURY CLIENT QUESTIONNAIRE**

Date of Initial Consultation: \_\_\_\_\_  
Client Referred by: \_\_\_\_\_

CLIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_

DEFENDANTS: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Is any Defendant a Municipality, such as CTA, PACE, or METRA? Yes / No

TYPE OF ACCIDENT (circle): Car Accident Slip and Fall Dog Bite Dram Shop

Was a police report or incident report made? Yes / No

Is this report in your possession? Yes / No

Police Agency (ie. Barrington P.D., Lake County Sherrif) \_\_\_\_\_

Police Report # (Typically located in the upper right-hand corner) \_\_\_\_\_

Last Four Digits of Your Social Security Number: XXX-XX-\_\_\_\_\_

Marital Status: Single / Married

Spouse: \_\_\_\_\_

Spouse's Contact Number (in case of emergency): \_\_\_\_\_

Were any minor children injured in this incident? Yes No

If yes, who? \_\_\_\_\_

Name of Current Employer: \_\_\_\_\_

Approximate yearly salary: \_\_\_\_\_

Start Date with Employer: \_\_\_\_\_

Estimated Wage Loss Due to Injury: \_\_\_\_\_

**ACCIDENT**

Time of Day When Accident Occurred: \_\_\_\_\_

Location: \_\_\_\_\_

Weather Conditions: \_\_\_\_\_

Were there Passengers in any of the Involved Vehicles (if applicable)? Yes No

If Yes, Please Provide Name and Contact Number:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Were there any Witnesses? Yes No

If Yes, Please Provide Name and Contact Number:

1) \_\_\_\_\_

2) \_\_\_\_\_

Did you give any statements to anyone, including any insurance company? Yes No

If Yes, to Whom? \_\_\_\_\_

What was said?: \_\_\_\_\_

\_\_\_\_\_

Any Pictures Taken of Scene/Property/Injuries? Yes No

Who has Possession of the Pictures? \_\_\_\_\_

Have you been contacted by the Defendant's Insurance Company? Yes No

Which Insurance Company? \_\_\_\_\_

Did they provide a Claim Number? Yes No

Who is your Automobile Insurance Carrier? \_\_\_\_\_

What are your Underinsured/Uninsured Coverage Policy Limits? \_\_\_\_\_

Do you have Med Pay Coverage on your policy? \_\_\_\_\_

If yes, how much is your Med Pay policy limit? \_\_\_\_\_

Description of Accident (Be very specific):

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If possible, please diagram:

**INJURIES**

Client's Initial Injuries (Be very specific): \_\_\_\_\_

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**LIST OF MEDICAL PROVIDERS**

Client's Treatment (including ambulance, ER, hospitals, therapy, and physicians):

1. Name of Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date(s) of Treatment: \_\_\_\_\_  
Future Appointments? \_\_\_\_\_  
Bill: \$ \_\_\_\_\_
2. Name of Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date(s) of Treatment: \_\_\_\_\_  
Future Appointments? \_\_\_\_\_  
Bill: \$ \_\_\_\_\_
3. Name of Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date(s) of Treatment: \_\_\_\_\_  
Future Appointments? \_\_\_\_\_  
Bill: \$ \_\_\_\_\_
4. Name of Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Date(s) of Treatment: \_\_\_\_\_  
Future Appointments? \_\_\_\_\_  
Bill: \$ \_\_\_\_\_

Is there any reason that you feel that there may be a question as to whether your injuries were a result of this accident? \_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL AND LITIGATION HISTORY**

Has the client ever been in a previous accident?    Yes    No

If Yes, Please List: \_\_\_\_\_  
\_\_\_\_\_

Has the client suffered from a past serious illness or injury?    Yes    No

If Yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Has the client been hospitalized in the last 10 years?    Yes    No

If Yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Have you ever filed a claim or lawsuit for personal injuries or workers comp before?    Yes    No

If Yes, please list the subject matter, parties involved, court number, court location, settlement amount: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who is your Health Insurance Carrier? \_\_\_\_\_

Policy Number? \_\_\_\_\_

Is this Health Insurance Plan provided by your Employer?    Yes    No

Are you enrolled in Medicare or Medicaid?    Yes    No

CURRENT LIST OF MEDICAL BILLS:

Ambulance _____	\$ _____
Hospital _____	\$ _____
Hospital _____	\$ _____
Doctor _____	\$ _____
Doctor _____	\$ _____
Doctor _____	\$ _____
Physical Therapy _____	\$ _____
X-rays (Taken where?) _____	\$ _____
Drugs/Prescriptions _____	\$ _____
Medical Equipment _____	\$ _____
Property Damage _____	\$ _____
Other _____	\$ _____
Total Bills to Date:	\$ _____

**NOTE:** Moving forward, please continue to provide us with all medical records/bills or other pertinent documents connected to the accident. Thank you for taking the time to complete this form. We look forward to working with you!

**Barrington Injury Attorneys**  
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