

**NELSON LAW**  
**PERSONAL INJURY INTAKE QUESTIONNAIRE**

Welcome. Thank you for giving us an opportunity to evaluate your legal problem. Please complete this intake questionnaire so we can properly analyze your case. Your response to any sensitive or personal matter will be held in the strictest confidence.

- The quality of our advice and assistance depends on your honest, candid, and complete responses to this questionnaire. ***Omissions or misrepresentations, now or in the future, could hurt or even destroy your case.***
- You authorize the firm to undertake whatever additional investigation it deems necessary before agreeing to represent you.
- We don't mean to pry, but all of the information requested is relevant to our legal analysis and opinion.
- This consultation does not mean that the firm or any of its attorneys have agreed to represent you.
- ***You and the firm must sign a written representation agreement before the firm will represent you.***

\_\_\_\_\_  
Your signature

\_\_\_\_\_  
Date

**Issues**

*Issues* (Circle all that may apply): Car Accident / Personal Injury / Medical Malpractice / Harassment / Assault/Battery

Other: \_\_\_\_\_

**Personal Information**

<i>Name (s)</i>	Last	First	Middle	Title
Legal Name	_____			
Previous Name (s)	_____			
Professional Name	_____			

<i>Address (es)</i>	Street	Apt/Suite	City	State	Zip
Home	_____				
Work	_____				
Mailing	_____				
Email	_____				
Other	_____				

*Telephone (s)*  
Home \_\_\_\_\_ Work \_\_\_\_\_ Fax \_\_\_\_\_ Mobile \_\_\_\_\_  
Other \_\_\_\_\_ In an emergency call \_\_\_\_\_

**Current Employer**

<b>Family Information</b>	Name	Age	Employer	Position
Spouse	_____			
Children	_____			



# Personal Injury Intake Questionnaire – Page3

*Witnesses (Include all persons who may have knowledge, even if hostile to your position)*

Name	Relationship	Subject of Knowledge	Phone

**Medical History (including if you claim emotional distress or physical injuries)**

*Current Injuries/Medical Problems* (in order of severity)

\_\_\_\_\_

*Current Medical Treatment*

\_\_\_\_\_

*Estimated Medical Expenses*

Expenses to date \_\_\_\_\_ Future Expenses \_\_\_\_\_

Amount not covered by insurance or Medicare \_\_\_\_\_

*Health Providers for treatment from accident* (also list one-time providers such as ambulance, paramedics, emergency room, and radiologists)

Name	Address	Phone	Specialty

*Prognosis* (Circle all that apply ) prognosis unknown / recovery expected / permanent injury / some disability expected / future surgery expected / other \_\_\_\_\_

*Previous injuries, diseases, hospitalizations, surgeries, alcohol or substance abuse, eating disorders,*

Year	Condition	Treating Health Provider	Status (healed, under control, etc.)

**Insurance Information**

√ *Health Insurance.* Carrier \_\_\_\_\_ Policy Holder \_\_\_\_\_

Employment Benefits Coordinator \_\_\_\_\_

Type: Group / Individual / HMO / PPO / Conversion / Medicare Supplement \_\_\_\_\_

√ *Disability Insurance.* Carrier \_\_\_\_\_ Policy Holder \_\_\_\_\_

Monthly Benefit \_\_\_\_\_ Waiting Period \_\_\_\_\_

√ *Workers Compensation.* \_\_\_\_\_ Claim No. \_\_\_\_\_

Adjuster's Name & Phone \_\_\_\_\_