

**Jackson & Wilson's Confidential Client Questionnaire**

Name of Claimant:

\_\_\_\_\_

First	Middle	Last
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Referring Person: \_\_\_\_\_

**I. Personal Data**

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Married:  Yes  No If yes, please provide the following information:

Spouse's Full Name: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_

Date and Place of Marriage: \_\_\_\_\_

Children:  Yes  No If yes, please provide the following information:

**II. Children**

1. Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dependent on you?  Yes  No

If yes, social security number: \_\_\_\_\_

2. Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dependent on you?  Yes  No

If yes, social security number: \_\_\_\_\_

3. Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dependent on you?  Yes  No

If yes, social security number: \_\_\_\_\_

4. Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dependent on you?  Yes  No

If yes, social security number: \_\_\_\_\_

Name any other dependents, other than spouse and children, including date of birth and social security number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### III. Education

Highest grade in school: \_\_\_\_\_

Name of last school attended: \_\_\_\_\_

City and State of last school: \_\_\_\_\_

### IV. Prior Claims History

Have you ever been involved in any litigation?  Yes  No

If yes, please provide the following information:

Nature and reason for case: \_\_\_\_\_

Outcome: \_\_\_\_\_

Have you ever filed a Workers' Compensation claim?  Yes  No

If yes, please provide the following information:

For what type of injury: \_\_\_\_\_

Date of claim: \_\_\_\_\_

Outcome: \_\_\_\_\_

Have you ever been convicted or arrested for a crime?  Yes  No

If yes, please explain: \_\_\_\_\_

### V. Personal Health History

1. Have you ever smoked cigarettes?  Yes  No

If yes, when, how often and for how long? \_\_\_\_\_

2. Do you currently smoke cigarettes?  Yes  No

3. Were you smoking at the time you were diagnosed with the injury indicated above?

Yes  No

If yes, how often and how much? \_\_\_\_\_

4. Do you currently drink alcohol?  Yes  No

If yes, please circle one description:      Heavy              Moderate              Light      None

Have you ever been to an AA meeting?  Yes  No

5. Describe your dietary fat intake (circle one): Heavy      Moderate      Light      None

6. Describe your physical activity on a daily basis: \_\_\_\_\_

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### VI. Past Medical History

Please provide the following information:

1. Your prior health status (circle one):      Excellent      Good      Fair      Poor

2. Prior health history, including any prior hospitalizations and injuries, including approximate dates: \_\_\_\_\_

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## VII. Treating Physicians

Please provide the name of any and all physicians or facilities that have treated you for 10 years prior to the adverse event up to and including the present time. Please include your primary care physician, internist, cardiologist, vascular surgeon, pulmonologist, neurologist, neurosurgeon, psychologist, psychiatrist, social worker, etc. Please use the back of this paper or additional paper if more space is needed.

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Physician Name	Specialty	Reason for Treatment
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Dates of Treatment

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Street Address, City, State, Zip Code	Telephone Number
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Physician Name	Specialty	Reason for Treatment
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Dates of Treatment

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Street Address, City, State, Zip Code	Telephone Number
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Physician Name	Specialty	Reason for Treatment
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Dates of Treatment

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Physician Name	Specialty	Reason for Treatment
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Dates of Treatment

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Street Address, City, State, Zip Code	Telephone Number
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Physician Name	Specialty	Reason for Treatment
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Dates of Treatment

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Street Address, City, State, Zip Code	Telephone Number
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**VIII. Incident Information**

1. Date and Time of Incident: \_\_\_\_\_

2. Location of Incident: \_\_\_\_\_

3. Did the incident occur within the scope of your employment?  Yes  No  
If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Did the incident occur within the scope of the responsible party's employment?  
 Yes  No  
If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Names, addresses, and telephone numbers of any witnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Names, addresses, and telephone numbers of persons who will have knowledge of your case:

Work-related:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Friends: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Tell us what you believe happened (Use additional paper, if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Are there any photographs or video of the scene, people, vehicles or anything else?

Yes  No  
If yes, describe:

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**IX. (Motor Vehicle Case)**

1. Do you carry medical payment coverage insurance?  Yes  No

Amount: (1) \_\_\_\_\_ Company \_\_\_\_\_

Amount: (2) \_\_\_\_\_ Company \_\_\_\_\_

2 Your Automobile Insurance:

Amount: (1) \_\_\_\_\_ Company \_\_\_\_\_

Amount: (2) \_\_\_\_\_ Company \_\_\_\_\_

3. Identify the liability insurance carrier and policy number, adjuster and claim number, if known of other driver(s):

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4. Your Uninsured Motorists' Insurance:

Amount: (1) \_\_\_\_\_ Company \_\_\_\_\_

Amount: (2) \_\_\_\_\_ Company \_\_\_\_\_

5. Your Vehicle:

Type of Vehicle: \_\_\_\_\_ Year: \_\_\_\_\_

Owner of Vehicle: \_\_\_\_\_

Driven from accident scene: \_\_\_\_\_ Towed by whom: \_\_\_\_\_

Approximate damage to vehicle: \_\_\_\_\_

6. Other Vehicle(s) Involved:

Type of Vehicle: \_\_\_\_\_ Year: \_\_\_\_\_

Owner of Vehicle: \_\_\_\_\_

Driven from accident scene: \_\_\_\_\_ Towed by whom: \_\_\_\_\_

Approximate damage to vehicle: \_\_\_\_\_

7. Where were you in vehicle? \_\_\_\_\_

8. Name and address of investigating authority (Police Dept., Sheriff, Highway Patrol, etc.):

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9. Did you or the other driver(s) receive any citation?  Yes  No

If yes, explain what (you) (other driver) were cited for: \_\_\_\_\_

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10. What were the weather and road conditions like? \_\_\_\_\_

11. Provide accident report if you have it:  Yes  No

12. Had you or anyone else been drinking or taking drugs to your knowledge?  Yes  No  
If yes, describe:

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13. How did you leave the scene?

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**X. (Product Liability Cases)**

1. Describe in detail the product that you believe injured you:

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2. Who owns the product?

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3. Where is the product?

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4. Do you have access to the product? \_\_\_\_\_

5. How old is the product? \_\_\_\_\_

6. Do you or does anyone else to your knowledge have any photographs of the product taken shortly after the incident?  Yes  No

If yes, where are the photographs?

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**XI. (Premises Liability Cases)**

1. To whom was the incident reported?

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2. Were any photographs taken of the scene or the cause of the incident shortly afterwards?

Yes  No

If yes, where are the photographs?

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3. What were you wearing, including your shoes?

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4. Do you still have your clothing and shoes?  Yes  No

5. Did the incident occur outside or inside? \_\_\_\_\_

## **XII. (Medical Negligence Cases)**

1. Name, address and telephone number of every person or entity who you believe was the cause of your injuries or illness and why you believe that.

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2. Were any photographs or videotapes taken of you, your treatment or your injuries?

Yes  No

If yes, where are they?

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## **XIII. Immediate Injury Information**

1. What (were) are all of your injuries from the incident? (describe in detail):

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2. Name and address of any ambulance service:

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3. Name and address of hospital where taken:

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**XIV. Miscellaneous Information**

1. Health Insurance

Do you have full health insurance coverage?  Yes  No

If no, what percentage of your medical bills are paid by insurance? \_\_\_\_\_%

Name of insurance carrier: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Primary Policyholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Date you started with this insurance carrier: \_\_\_\_\_

Prior insurance carrier names and dates with this carrier: \_\_\_\_\_

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2. Medicare

Do you currently have Medicare?  Yes  No

If yes, date started: \_\_\_\_\_

3. Medicaid

Have you ever been on Medicaid?  Yes  No

If yes, date started and date stopped:

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4. Do you believe that your doctor would be willing to talk to us about his/her experience and knowledge of your injury?  Yes  No

Comments:

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5. If so, do you believe that you should be the first person to contact him/her, or may we have permission to contact your physician first?

Comments:

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6. Do you believe that any medical mistakes were made in connection with the diagnosis or treatment of the injury you sustained?  Yes  No

If yes, please explain and include all relevant dates and describe any legal action you have taken:

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**XV. Military History**

Have you been in the military service? \_\_\_\_\_

If so, give branch of service: \_\_\_\_\_

Type of discharge: \_\_\_\_\_

Dates of service and discharge: \_\_\_\_\_

Have you ever been rejected for military service because of physical, mental or other reasons? \_\_\_\_\_

If so, explain: \_\_\_\_\_

Do you have any service-connected injuries or disabilities? \_\_\_\_\_

If so, give details: \_\_\_\_\_

Percentage of disability: \_\_\_\_\_

Present condition of service-connected injury or disability: \_\_\_\_\_

Do you receive payments for service-connected injuries? \_\_\_\_\_

**XVI. Employment History**

1. Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Title: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Wages/Earnings: \_\_\_\_\_

Dates: \_\_\_\_\_

Disability? \_\_\_\_\_

If yes, describe with inclusive dates: \_\_\_\_\_

2. Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Title: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Wages/Earnings: \_\_\_\_\_

Dates: \_\_\_\_\_

Disability? \_\_\_\_\_

If yes, describe with inclusive dates: \_\_\_\_\_

Did you ever lose time from work as a result of the injury you sustained from the incident?

Yes  No

If yes, give the dates you were unable to work: \_\_\_\_\_

Did you lose earnings as a result of being unable to work?  Yes  No

If yes, state the amount of earnings lost:

\$ \_\_\_\_\_

**XVII. Statute of Limitations**

(To be completed by Attorney)

Jurisdiction (County/State): \_\_\_\_\_

Jurisdiction Statute of Limitations: \_\_\_\_\_

Date of incident or negligence: \_\_\_\_\_

Thank you for your patience in completing this confidential questionnaire.

So that we can effectively provide you with proper legal counsel, please return the completed questionnaire to our office at least one day prior to your appointment:

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