Jackson & Wilson's Confidential Client Questionnaire

Name of Claimant:
_____
First Middle Last
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:
_____
_____
_____

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: _____
_____
_____

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:_____
_____
_____

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.

Physician Name Specialty Reason for Treatment

Dates of Treatment

Street Address, City, State, Zip Code Telephone Number

Physician Name Specialty Reason for Treatment

Dates of Treatment

Street Address, City, State, Zip Code Telephone Number

Physician Name Specialty Reason for Treatment

Dates of Treatment

Street Address, City, State, Zip Code Telephone Number

Physician Name Specialty Reason for Treatment

Dates of Treatment

Street Address, City, State, Zip Code Telephone Number

Physician Name Specialty Reason for Treatment

Dates of Treatment

Street Address, City, State, Zip Code Telephone Number

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:
_____
_____
_____

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):
_____
_____

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.):
_____
_____

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

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

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:

_____
_____

13. How did you leave the scene?

_____
_____

X. (Product Liability Cases)

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Who owns the product?

_____
_____
_____
_____
_____

3. Where is the product?

_____
_____
_____
_____

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?

_____
_____
_____

XI. (Premises Liability Cases)

1. To whom was the incident reported?

_____
_____
_____

2. Were any photographs taken of the scene or the cause of the incident shortly afterwards?
☐ Yes ☐ No
If yes, where are the photographs?

_____
_____

3. What were you wearing, including your shoes?

_____
_____
_____

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.

_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Were any photographs or videotapes taken of you, your treatment or your injuries?
☐ Yes ☐ No
If yes, where are they?

_____
_____

XIII. Immediate Injury Information

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

_____
_____
_____
_____
_____
_____
_____

2. Name and address of any ambulance service:

_____
_____

3. Name and address of hospital where taken:

_____
_____

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: _____
_____
_____

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:
_____

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:

_____
_____
_____

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:
_____
_____
_____

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:_____
_____
_____
_____

7. Please list the name(s), complete addresses and telephone numbers of all pharmacies where you had your prescriptions filled for the five years up to and including present:

_____
Name
_____
Street Address
_____
City, State, Zip Code Telephone Number

_____
Name
_____
Street Address
_____
City, State, Zip Code Telephone Number

_____
Name
_____
Street Address
_____
City, State, Zip Code Telephone Number

8. How has the incident/accident affected you? (Use additional paper, if necessary)
_____
_____
_____
_____
_____
_____
_____
_____
_____

9. What things do you like to do?

_____
_____
_____
_____

10. What are your likes and dislikes?

_____
_____
_____
_____
_____

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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