THOMPSON, THOMPSON & GLANVILLE, PLC

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PERSONAL INJURY INITIAL CLIENT INTERVIEW (AUTO)

Date: _______________ Referral Source: _____________________________________

BACKGROUND INFORMATION

Full Name: ____
First Middle Last

Other names known by (including maiden name):_________________________________
Address: ____
City, State, Zip: ____
Telephone: Home _______________ Cell _______________ Other _______________
Email Address: ____
Date of Birth: ________________ Social Security No.: ______-______-______
Driver's License No.: ____________________________
Marital Status (Check One): _____ Married _____ Single _____ Divorced
_____ Separated _____ Widowed/Widower
Spouse's Name: ____
First Middle Last

OCCUPATION

Employer: ____
Address: ____
Job Title: __________________________________ How long employed? _____________
Name of Supervisor: ________________________ Telephone: ____________________
Your last date worked before illness or injury: ___________________________________
Rate of Pay: _________ Per: Month _________ Week ________ Bimonthly ________
Date returned to work: ____

INCIDENT INFORMATION

Date of Injury: _______________ Time: _____________ SOL: _____________________
Location: ____________________________________ County: _____________________
Weather Conditions: ____
Status: (e.g., driver, passenger, pedestrian); If passenger, who is driver? ____________
____

Were police called? Yes _____ No _____ Agency: _______________________________
Was fire department called? Yes _____ No _____ Agency: _______________________
Was ambulance called? Yes _____ No _____ Agency: ____________________________
List any citations given and to whom: ____

4.

Describe what happened: ____
____
____
____
____
____
____

Draw a diagram of accident scene:

INSURANCE INFORMATION

Vehicle (Year/Make/Model): ____
Plate Number: ____
Describe damage to your vehicle: ____
Location of your vehicle: ____
Property damage resolved? Yes _________ No _________
Were photos taken? ______ Location of photos: ___________________________

1. Vehicle in Which You Were Driver/Passenger at time of Accident

Auto Insurance Company: ____
Address: ____
Policyholder/Insured (If Not You):_______________________________________
Policy Number: _______________________ Claim Number: ________________________
Adjuster Name: _______________________________ Phone Number: ______________
Policy Limits: ____________________ PIP application completed? Yes ______ No ______

2. Your Vehicle (If Different) or Vehicle on which You Are Named Insured or Household Member

Auto Insurance Company: ____
Address: ____
Policyholder/Insured (If Not You):_______________________________________
Policy Number:_______________________ Claim Number: _______________________
Adjuster Name: ________________________________ Phone Number: _____________
Policy Limits: ____________________ PIP application completed? Yes ______ No ______

3. Were You On the Job at the Time of the Accident? Yes ______ No ______

Workers' Compensation Insurance Company: ___________________________________
Address: ____
Insured: _______________________________Claim Number: _____________________
Adjuster Name: _______________________________ Phone Number: ______________

4. Your Health Insurance Company: ______________________________________

Address: ____
Policyholder: ____________________________ ID/Policy Number:___________________

OTHER PARTY INFORMATION

Other Party #1
Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Driver's License No.: ____________________
Vehicle: ____________________ Plate Number: ____________________
Insurance Company: ____________________ Adjuster Name: ____________________
Policy Number: ____________________ Claim Number: ____________________
Policy Limits: ____________________ Recorded statement given? Yes _____ No _____

Other Party #2
Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Driver's License No.: ____________________
Vehicle: ____________________ Plate Number: ____________________
Insurance Company: ____________________ Adjuster Name: ____________________
Policy Number: ____________________ Claim Number: ____________________
Policy Limits: ____________________ Recorded statement given? Yes _____ No _____

***For additional defendants, use the back of this form.**

WITNESS INFORMATION

Names of any witnesses: (Please include addresses and telephone numbers, if known.)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

INJURIES/MEDICAL TREATMENT

List all INJURIES that you received as a result of this accident. ____________________

____

____

____

____

List the names of every HOSPITAL you have been seen at since the accident occurred whether or not you were treated for injuries caused by the accident. Include dates and reasons for each hospitalization.

Date of Admission	Hospital	Reason
Date of Admission	Hospital	Reason
Date of Admission	Hospital	Reason

List the names and addresses of all DOCTORS who have treated you for your injuries.

____
____
____
____
____
____

List the names and addresses of all PHYSICAL THERAPISTS who have treated you for your injuries.

____
____
____
____
____
____

Describe every past injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.)

____
____
____
____
____

List all illnesses or injuries for which you were being treated at the time of the accident.

____
____
____
____
____
____

ADDITIONAL BACKGROUND INFORMATION

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons, and results.

____
____
____
____
____
____

Have you ever been arrested? Yes ______ No _______
If yes, please provide the following information:
Date: _______ Charge:____

Have you ever been convicted of a crime? Yes____ No____
If yes, please provide the following information:
Date: ________Charge:____
Date: ________Charge:____
Result (fine, penalty, etc.):____
____
____

Have you ever filed bankruptcy? Yes _____ No _______
If yes, please provide the following information:
Date: ________Location:____

Have you ever been represented by another attorney? Yes _______ No_______
Name:____
Address:____
Reason:____

Give any other information you feel we should have to represent you effectively in this case ____
____
____
____

Please give a brief summary of what you think a fair outcome would be in your case.
____
____
____
____

All items below are needed to complete your personal injury file, if they apply to your case. Bring in originals, or copies as soon as possible.

Items needed:

[ ] Tax returns with schedules and W-2s - last two years
[ ] Paycheck stubs from last two months
[ ] No-Fault Proof of Insurance
[ ] Health Insurance card
[ ] Health Insurance policy
[ ] Disability Insurance policies - short or long term
[ ] Medical bills from all doctors or hospitals
[ ] Explanation of benefits from all insurance companies