Jesse James Law Firm

Serious Injuries | Serious Crimes | Serious Results

PERSONAL INJURY QUESTIONNAIRE
(PLEASE PRINT AND BRING WITH YOU)

Name: _____ Date: _____

Address: _____
(Street) (City) (State) (Zip Code)

Phone: (Home) _____ (Work) _____ (Cell)_____

Date of Birth: _____ SSN: _____ Email Address:_____

Marital Status: Married/Divorced/Separated/Widowed Spouse's Name_____

Description of Injury _____ _

Please Check the Box(s) that Pertain to Your Injuries:

Loss of Consciousness [ ]	Soft Tissue [ ]	Bruising [ ]	Scarring [ ]
Head Injury [ ]	Radiating Pain [ ]	Lacerations [ ]	
Headaches [ ]	Disc Injury [ ]	Broken Bones [ ]	

Treatment Since Accident:

Ambulance [ ]	Medical Doctor [ ]	Physical Therapy [ ]	Surgery [ ]
Emergency Room [ ]	Naturopath [ ]	Massage Therapy [ ]	Future Surgery [ ]
Hospital Admission [ ]	Chiropractor [ ]	Acupuncture [ ]	

Prior Accident(s): Date(s) _____

Prior L&I claim(s): Date(s) _____

Other Medical History_____

Family Doctor_____

Interests/Hobbies _____

Education _____

Children (s) Name\ages_____

Driver's License Number_____

ACCIDENT INFORMATION

Who can we thank for your referral? _____

Date of Injury _____ Time of Day _____ a.m. / p.m.

Location of Accident: (Name of street, road or highway)

_____

_____

_____

(Intersection)
(County) _____ (City) _____

(Other)
Direction: North South East West

Police Investigated: ☐State Patrol ☐County ☐City ☐No Investigation ☐Other (please specify)

Case Number _____ Officer's Name _____

Were citations issued? ☐Yes ☐No

If so, to Who and What
Violation_____

Were you the:
☐Driver ☐Passenger ☐Pedestrian ☐Motorcyclist ☐Bicyclist

Were you wearing a seatbelt? ☐Yes ☐No

Did an Airbag Deployed? ☐Yes ☐No

No. of vehicles involved: _____

No. of people in your vehicle: _____ Your Speed:_____mph

No. of people in other vehicle: _____ Other Vehicle's Speed (if known):_____mph
Describe Accident (please be as detailed as possible)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Had you consumed any (check all that apply) ڤAlcohol ڤDrugs ڤMedication(s) 24hrs prior to the accident: ڤYes ڤNo
If yes, what, how much and what time of day_____
_____
_____
_____

DEFENDANT / INSURANCE INFORMATION

Name of Defendant: _____

Address
_____
_____
_____

Insurance Carrier _____

Name of Insurance Adjuster:_____

Address
_____
_____

Phone_____

Acting Within Scope of Employment: Yes / No
Company Name_____

YOUR INSURANCE INFORMATION

Auto Insurance Carrier _____

LIABILITY _____ UM./ UIM_____ PIP_____

Policy Holder Name (if different than self)_____

Name of Insurance Adjuster_____

Address_____
_____

Phone No._____

Medical Insurance _____

Address_____
_____

Acting Within Scope of Employment: Yes / No L&I Claim No.: _____
PIP Claim No._____
Plan No._____
Phone No._____

WITNESS INFORMATION

(please use additional sheets as necessary)

Name of Witness_____Phone_____

Address: _____
_____

EMPLOYMENT INFO.

Current Employer_____

Address_____
_____

Phone No. _____ Supervisor's Name_____
Title of Your Position _____
Salary $_____/year $_____/month
Description of Duties_____
_____

Has accident caused you to lose time from work? ڤYes ڤNo

Employer at time of accident, if different from above _____
Address_____
_____

Employer's Phone No. _____ Supervisor's Name _____
Title of Your Position _____
Salary $_____ /year $_____/month
Description of Duties_____
_____

Has accident caused you to lose time from work? ڤYes ڤNo

PROPERTY DAMAGE INFORMATION

Is Property Damage an Issue? ڤYes ڤNo

If so, has your Property Damage been Resolved: ڤYes ڤNo

If so, by who? _____

Your vehicle description: Make\Model _____
Your property damage amount: $_____
Was your vehicle towed? ڤYes ڤNo
If so, by who? _____

Others vehicle description: Make\Model _____
Their property damage amount: $_____
Was their vehicle towed? ڤYes ڤNo
If so, by who? _____

TREATMENT RESULTING FROM CURRENT ACCIDENT

Ambulance _____ Phone _____

Address: _____

Hospital _____ Phone _____

Address: _____

Doctor's Name _____ Phone _____

Address: _____

Current Treatment Frequency_____
(visits per week/month) (next follow-up exam)

Doctor's Name _____ Phone _____

Address: _____

Current Treatment Frequency_____
(visits per week/month) (next follow-up exam)

Doctor's Name _____ Phone _____

Address: _____

Current Treatment Frequency_____
(visits per week/month) (next follow-up exam)

Doctor's Name _____ Phone _____

Address: _____

Current Treatment Frequency_____
(visits per week/month) (next follow-up exam)

Pharmacy _____ Phone _____

Address: _____

Other Out of Pocket Expenses _____
_____
_____

Please add any additional information or comments relative to your accident in the space below which you feel will help us in obtaining a satisfactory settlement for you. For example, consider any statements made by the defendant or yourself, remarks of the police investigating the accident, and how the accident has affected your lifestyle, job responsibilities, and /or family life.

_____
Signature

Space Below For Office Use Only

5107 Central Avenue
St. Petersburg, FL 33710
P: (727) 327-5700 | F: (888) 757-1624
JesseJames@JesseJamesLawFirm.com