


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) Alcohol Drugs Medication(s) 24hrs prior to the accident: Yes No

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? Yes No

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? Yes No

PROPERTY DAMAGE INFORMATION

Is Property Damage an Issue? Yes No

If so, has your Property Damage been Resolved: Yes No

If so, by who? _____

Your vehicle description: Make\Model _____

Your property damage amount: \$ _____

Was your vehicle towed? Yes No

If so, by who? _____

Others vehicle description: Make\Model _____

Their property damage amount: \$ _____

Was their vehicle towed? Yes No

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

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