McSHANE & BRADY
ATTORNEYS AT LAW

CLIENT QUESTIONNAIRE

Your Name: ____

Date of Incident: ______________________________ **Time of Incident:** ___________________

Weather Conditions (If applicable): ____

Exact Location of Incident: ____

City/State: ____ **County:** ____________________

Witness:

First Name: ______________________________ **Last Name:** ______________________________ **Phone Number:** ___________________________ **Email:** _________________________________	**Address:** ________________________________ ____ **City**: __________________________________ **State**: __________________ **Zip:** ____________
First Name: ______________________________ **Last Name:** ______________________________ **Phone Number:** ___________________________ **Email:** _________________________________	**Address:** ________________________________ ____ **City**: __________________________________ **State**: __________________ **Zip:** ____________
First Name: ______________________________ **Last Name:** ______________________________ **Phone Number:** ___________________________ **Email:** _________________________________	**Address:** ________________________________ ____ **City**: __________________________________ **State**: __________________ **Zip:** ____________
First Name: ______________________________ **Last Name:** ______________________________ **Phone Number:** ___________________________ **Email:** _________________________________	**Address:** ________________________________ ____ **City**: __________________________________ **State**: __________________ **Zip:** ____________

PHOTOGRAPHS/VIDEO:

Photographs of injuries: Yes ☐ No ☐

Photographs of scene: Yes ☐ No ☐

POLICE REPORT:

Was a police report made? Yes ☐ No ☐

Do you have copy of the police report? Yes ☐ No ☐

Police Report Number:_____

INJURIES:

Please describe your injuries from the incident: _____

_____

_____

_____

_____

_____

_____

LOST WAGES:

Did you lose wages as a result of the incident? Yes ☐ No ☐

Employer: _____

Job Duties: _____

How many missed days of work due to incident: _____

Average weekly/monthly/yearly wages: _____

Immediate Supervisor: _____

LIENS/SUBROGATION INFORMATION:

Are you aware of any medical or other liens due the incident? Yes ☐ No ☐

Are you a Medicare and/or Medicaid recipient? Yes ☐ No ☐

HIC# (Medicare ID) _____

Please list any and all liens along with the amount: _____

INSURANCE:

Do you have Health Insurance? Yes ☐ No ☐

Name of Insurance Co.: _____ Telephone: _____

Address: _____ City/State/Zip: _____

Policy Number: _____

CURRENT MEDICAL CONDITIONS – RELATED TO THE INCIDENT:

Please list all medical treatment providers you received as a result of the incident:

Were Ambulance Services Needed? If yes, please list them below:

Ambulance Service Name:	Address: _____ City: _____ State: _____ Zip: _____

Were you treated at a Hospital? If yes, please list it below:

Hospital Name:	Address: _____ City: _____ State: _____ Zip: _____ Amount of days in the hospital: _____

Were you treated by Physicians? If yes, please list them below:

Physician's Name	Address: _____ City: _____ State: _____ Zip: _____
Physician's Name	Address: _____ City: _____ State: _____ Zip: _____
Physician's Name	Address: _____ City: _____ State: _____ Zip: _____
Physician's Name	Address: _____ City: _____ State: _____ Zip: _____
Physician's Name	Address: _____ City: _____ State: _____ Zip: _____
Physician's Name	Address: _____ City: _____ State: _____ Zip: _____

Did you receive Physical Therapy? If yes, please list below:

Therapist's Name:	Address: _____ City: _____ State: _____ Zip: _____
Therapist's Name:	Address: _____ City: _____ State: _____ Zip: _____

Were you treated by a Chiropractor? If yes, please list below:

Chiropractor's Name:	Address: _____ City: _____ State: _____ Zip: _____

Did you get Prescriptions as a result of the incident? If yes, please list pharmacy below:

Pharmacy Name:	Address: _____ City: _____ State: _____ Zip: _____

Any additional healthcare providers not listed above?

Name:	Address: _____ City: _____ State: _____ Zip: _____
Name:	Address: _____ City: _____ State: _____ Zip: _____
Name:	Address: _____ City: _____ State: _____ Zip: _____

PRIOR MEDICAL CONDITIONS:

Please list all serious medical condition and/or treatment PRIOR to the incident:

Condition/Treatment: _____ Treating Physician: _____	Date of Onset: _____ Current Status: _____
Condition/Treatment: _____ Treating Physician: _____	Date of Onset: _____ Current Status: _____
Condition/Treatment: _____ Treating Physician: _____	Date of Onset: _____ Current Status: _____
Condition/Treatment: _____ Treating Physician: _____	Date of Onset: _____ Current Status: _____