**INJURY INTAKE QUESTIONNAIRE**

Name ________________________________
Date of birth ____/____/____
Social security number _____-_____-_______
Your driver license number ________________ Has your driver license ever been revoked __________
Address ___________________________
___________________________
___________________________
Home phone (_____) ______-________
Work phone (_____) ______-________
Mobile phone (_____) ______-________
E-mail address ____________________________________

Best method to reach you ___________________________

Marital Status _____________________ If married, spouse's name ____________________________

On what date did your injury occur? ____/____/____

Where did your injury occur? City _________________ State ______ County ___________________

Year, make, model & color of your car ___________________________________________________

Year, make, model & color of the other car(s) ___________________________________________

________________________________________________________________________________

Name of your car insurance, claim number, adjuster information _______________________________

________________________________________________________________________________

Name of third party car insurance information, claim number, adjuster information ________________

________________________________________________________________________________



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Name of the person who hit you, their address and license number: ______________________________
________________________________________________________________________________________

Did you get a property damage estimate? If yes, what is the amount? Do you have any pictures from the accident? ______________________________________________________

Are you a MediCal or MediCare recipient? If yes, which? Member number ________________________

Describe the accident – City, streets, time of the day, etc. Tell us what happened.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Describe and list your injury(ies), including injuries known at the scene of the accident and after.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Was there a police report? __________________________________
If yes do you a have a copy of it? ____________________________

Was anyone else involved in the accident with you? __________________________________________
List all names ____________________________________________________________________________
________________________________________________________________________________________

Was there any witnesses? ________________________________________________________________
If yes list their names and contact information?____________________________________________
________________________________________________________________________________________

List all hospitals, doctors, urgent care clinics, primary care doctors and other health care providers (i.e. chiropractors, physical therapists) who have treated your injuries, including their names, addresses, and telephone numbers.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________



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______________________________________________________________________________
______________________________________________________________________________

List the names, addresses, and telephone numbers of all medical insurance companies that may be involved (i.e. Kaiser, Anthem Blue Cross, Blue Shield, Alameda Alliance, Medi-Cal, Medicare).

________________________________
________________________________
________________________________
________________________________

Have you lost income as a result of your injuries? Yes __ Amount $_________ No __

Employer's information ____________________________________________________
Employer's telephone number (_____) _______-_________

Income $__________ per ___________ (i.e. hour, biweekly, monthly)
Employer ______________________________________________________
Position and Duties ______________________________________________________
______________________________________________________________________
______________________________________________________________________

What income supporting records/documents do you have? (i.e. paystubs, tax forms - two months prior to the injury, the month of the injury and two month after the accident)
______________________________________________________________________________

Are you currently working? Yes _____ No _____ Returned to work on ____/____/____

Are you in pain? What are your limitations following the accident? What can you no longer do because of the injuries, describe? ___________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If married, has your spouse experienced any losses as a result of your injury? If so, describe.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Have you had any personal injury OR workers compensation matters in the past 10 years?
______________________________________________________________________________
______________________________________________________________________________

Do you have pictures of your injuries? How will you be forwarding them to us – mail or email?
______________________________________________________________________________



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