



**CLIENT INTAKE**  
**MOTOR VEHICLE ACCIDENT**

**Client Information**

Name \_\_\_\_\_ Today's date \_\_\_\_\_

Street Address \_\_\_\_\_ Date of birth \_\_\_\_\_

\_\_\_\_\_ Social Security Number \_\_\_\_\_

Driver's License Number \_\_\_\_\_ Phone (home) \_\_\_\_\_

Phone (work) \_\_\_\_\_ Phone (message) \_\_\_\_\_

Spouse's name \_\_\_\_\_ Children \_\_\_\_\_

(Is your spouse authorized to talk with these offices about your case? Yes No ) Referred by \_\_\_\_\_

**Accident Information**

Date of Accident \_\_\_\_\_ Time of accident \_\_\_\_\_ a.m. p.m.

Location of accident \_\_\_\_\_ Name of driver \_\_\_\_\_

(If not you, include contact info. on last page)

County accident in \_\_\_\_\_ Number of passengers in other car \_\_\_\_\_

Passengers \_\_\_\_\_ Witnesses \_\_\_\_\_

(Include contact info. on last page) (Include contact info. on last page)

Weather conditions \_\_\_\_\_ Road conditions \_\_\_\_\_

Were you wearing your seat belt? Yes No Were you working at the time? Yes No

Did police respond? Yes No Did anyone call 911? Yes No  
If yes, list case number \_\_\_\_\_ If yes, who called? \_\_\_\_\_

Did either driver receive a ticket? Yes No Did you take any pictures? Yes No  
If yes, who and for what? \_\_\_\_\_

Description of accident \_\_\_\_\_

**Other Driver's Information**

Name \_\_\_\_\_ Driver's License \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

Did driver go in an ambulance? Yes No Injuries \_\_\_\_\_

What did the driver say? \_\_\_\_\_



**Vehicle Information**

**YOUR VEHICLE**

License Plate Number \_\_\_\_\_

Owner \_\_\_\_\_  
(If not you, include contact info. on last page)

Make \_\_\_\_\_

Model/Year \_\_\_\_\_

Type/Color \_\_\_\_\_

Cost of repairs \_\_\_\_\_

Body shop \_\_\_\_\_

Describe damage \_\_\_\_\_  
\_\_\_\_\_

Was vehicle towed from scene? Yes No  
If yes, who towed it? \_\_\_\_\_

Do you want this office to represent you regarding your property damage claim? Yes No

**Insurance Information**

**YOUR VEHICLE**

Name of insured \_\_\_\_\_  
(If not you, include contact info. on last page)

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_  
\_\_\_\_\_

Policy Number \_\_\_\_\_

Claim Number \_\_\_\_\_

Adjuster \_\_\_\_\_

Did you give a taped statement? Yes No

**OTHER VEHICLE**

License Plate Number \_\_\_\_\_

Owner \_\_\_\_\_  
(If not driver, include contact info. on last page)

Make \_\_\_\_\_

Model/Year \_\_\_\_\_

Type/Color \_\_\_\_\_

Cost of repairs \_\_\_\_\_

Body shop \_\_\_\_\_

Describe damage \_\_\_\_\_  
\_\_\_\_\_

Was vehicle towed from scene? Yes No  
If yes, who towed it? \_\_\_\_\_

**OTHER VEHICLE**

Name of insured \_\_\_\_\_  
(If not driver, include contact info. on last page)

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_  
\_\_\_\_\_

Policy Number \_\_\_\_\_

Claim Number \_\_\_\_\_

Adjuster \_\_\_\_\_

Did you give a taped statement? Yes No



**Wage loss**

Name of Employer \_\_\_\_\_ Job title \_\_\_\_\_

Employer's address \_\_\_\_\_ Employer's phone \_\_\_\_\_

\_\_\_\_\_  
Supervisor's name \_\_\_\_\_

Job duties \_\_\_\_\_

Did your doctor issue a work release? Yes No Did your doctor issue work restrictions? Yes No  
If yes, for how long? \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

**Injuries**

Did an ambulance transport you? Yes No Did you go to the hospital? Yes No  
If yes, name ambulance \_\_\_\_\_ If yes, name hospital \_\_\_\_\_

List injuries immediately after accident \_\_\_\_\_

\_\_\_\_\_

List injuries for which you are currently treating \_\_\_\_\_

\_\_\_\_\_

Name all doctors who treated your injuries (include contact info.) \_\_\_\_\_

\_\_\_\_\_

List activities/hobbies your injuries restrict \_\_\_\_\_

\_\_\_\_\_

List day-to-day activities your injuries restrict \_\_\_\_\_

\_\_\_\_\_

List work activities your injuries restrict \_\_\_\_\_

\_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

(Include contact info.)

Who is your dentist? \_\_\_\_\_

(Include contact info.)

**Other Insurance**

Do you have health insurance? Yes No If yes, has it paid any bills? Yes No  
If yes, name \_\_\_\_\_ If yes, list bills \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_



Group Number \_\_\_\_\_ If yes, does it have a lien? Yes No

**Previous Injuries**

Is this your first car accident? Yes No Have you been injured on the job? Yes No  
If no, when? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Please list any surgeries, car accidents, work injuries, slips and falls, and other accidents for which you sought treatment in the past:

YEAR	INJURY	PHYSICIAN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Additional Contact Information**

Name \_\_\_\_\_ Relationship to accident \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to accident \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to accident \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to accident \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to accident \_\_\_\_\_

Street Address \_\_\_\_\_ Phone (home) \_\_\_\_\_

\_\_\_\_\_ Phone (work) \_\_\_\_\_