



CLIENT INTAKE
SLIP AND FALL

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 _____ County accident in _____

Witnesses _____ Did anyone call 911? Yes No
(Include contact info. on last page) If yes, who called? _____

Were you working at the time? Yes No Weather conditions _____

Did you take any pictures? Yes No

Description of accident _____

Business' Information

Name _____ Employee _____

Street Address _____ Supervisor _____

_____ Phone _____

Owner _____

What did the employees say? _____



Insurance Information
BUSINESS' INSURANCE

Name of insured _____
(If not business, include contact info. on last page)

Insurance Company _____ Policy Number _____

Insurance Address _____ 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

Have you been in a 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) _____

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