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Date of Appointment: _____
Attorney: _____

PERSONAL INJURY INTAKE FORM
PERSONAL INFORMATION

NAME: _____
ADDRESS: _____ CITY/STATE/ZIP_____
DATE OF BIRTH: _____ SSN: _____
TELEPHONE NUMBER: (H) _____ (C) _____
EMAIL: _____

ACCIDENT INFORMATION

DATE: _____ TIME: _____
LOCATION: _____
Street, City, State, Zip Code
POLICE DEPARTMENT: yes/no Name: _____
WITNESS NAMES: _____
WEATHER CONDITION: _____
OBSTRUCTIONS: _____
DESCRIPTION: _____
_____
_____
CITATIONS: _____
TAKEN TO HOSPITAL BY RESCUE SQUAD/AMBULANCE? _____ Yes _____ No
NAME OF SQUAD RESPONDING: _____

VEHICLE INFORMATION

VEHICLE NO. 1: (driving or a passenger of)
MAKE/MODEL/YEAR: _____
Wearing Seatbelt? Yes No
DRIVER: _____
OWNER: _____
PASSENGERS: _____
_____

VEHICLE NO. 2:
MAKE/MODEL/YEAR: _____
Wearing Seatbelt? Yes No
DRIVER: _____
OWNER: _____
PASSENGERS: _____
_____

INSURANCE: _____ INSURANCE: _____
POLICY NO.: _____ POLICY NO.: _____

PROPERTY DAMAGE INFORMATION

IS VEHICLE REPAIRABLE? _____ OR TOTAL LOSS? _____
WHERE IS VEHICLE NOW? _____
PHOTOS AVAILABLE? YES _____ NO _____
HAS PROPERTY DAMAGE BEEN PAID? YES ___ NO___ IF SO, BY WHOM?_____
AMOUNT OF DEDUCTIBLE: $_____
WAS DEDUCTIBLE REIMBURSED? YES _____ NO _____

INJURIES

INJURIES RECEIVED AS A RESULT OF THE ACCIDENT: _____
_____
_____
WERE YOU GIVEN EMERGENCY TREATMENT AT THE SCENE? YES ____ NO ___
DESCRIBE TREATMENT: _____
_____
HOSPITAL TREATMENT: _____
_____
INPATIENT? _____ OUTPATIENT? _____
DOCTOR(S) TREATED BY AT HOSPITAL: _____
PRESENT PHYSICAL CONDITION: (scarring, deformities, headaches, back pain, etc. due to this accident) _____
_____
_____

PRIOR MEDICAL HISTORY

PRIOR ACCIDENTS:

1) WHEN: _____
2) WHERE: _____
3) INJURIES: _____
4) TREATED BY: _____
_____

REPRESENTED BY ATTORNEY? IF YES, WHO? _____

PRIOR TREATMENT:

1) WITH CHIROPRACTOR: If so, with whom and for how long? _____
_____

2) HAVE YOU EVER RECEIVED TREATMENT FOR INJURIES TO THE SAME AREA(S) OF YOUR BODY AS YOU INJURED IN THIS ACCIDENT? _____ IF SO, WHEN AND BY WHOM WERE YOU TREATED? _____
_____
_____

EMPLOYMENT INFORMATION

PRESENT EMPLOYER: _____
EMPLOYER'S ADDRESS: _____
WORK PHONE NUMBER: _____
OCCUPATION: _____
SUPERVISOR/PERSONAL DIRECTOR: _____
DATES OF EMPLOYMENT: FROM _____ TO _____
DID YOU LOSE TME FROM WORK? YES _____ NO _____
DATE YOU RETURNED TO WORK? _____
AVERAGE WEEKLY EARNINGS? _____

HEALTH INSURANCE INFORMATION
(PROVIDE A COPY OF YOUR CARD)

DO YOU HAVE ANY OTHER TYPE OF MEDICAL COVERAGE? YES _____ NO _____
IF YES, DESCRIBE &: _____

AUTOMOBILE INSURANCE INFORMATION

FULL TORT or LIMITED TORT? (Pennsylvania only) _____
(Please provide a copy of the declaration page)
OWNER: _____
INSURER: _____
POLICY NUMBER: _____

MISCELLANOUS INFORMATION

ANY OTHER ATTORNEY CONSULTED? _____ IF SO, WHOM? _____
DID YOU SIGN A FEE AGREEMENT? YES _____ NO _____
WERE YOU INJURED ON THE JOB? YES _____ NO _____
NAME AND ADDRESS OF WORKER'S COMPERSATION CARRIER: _____
_____
DID YOU RECEIVE AN OFFER OF SETTLEMENT? IF SO, WHEN AND FOR HOW MUCH? _____

MEDICAL PROVIDERS

NAME AND ADDRESS OF MEDICAL PROVIDERS FOR THIS ACCIDENT:

1) _____
APPROXIMATE DATE OF TREATMENT: _____

2) _____
APPROXIMATE DATE OF TREATMENT: _____

3) _____
APPROXIMATE DATE OF TREATMENT: _____

4) _____
APPROXIMATE DATE OF TREATMENT: _____

5) _____
APPROXIMATE DATE OF TREATMENT: _____

6) _____
APPROXIMATE DATE OF TREATMENT: _____

7) _____
APPROXIMATE DATE OF TREATMENT: _____

8) _____
APPROXIMATE DATE OF TREATMENT: _____

PHILLIPS & ALLEN, P.A. provides for a free initial consultation for up to one half hour. Additional time will be billed at $300.00 per hour billed in one-quarter (1/4) hour increments. I understand that an Attorney/Client relationship is not established unless my case is accepted and I enter into a fee agreement with the assigned attorney. I have read and received this firm's privacy policy and understand that the privacy policy applies to all information provided to Phillips & Allen, P.A. regardless of whether I retain any attorney in the firm.

SIGNATURE: _____ Date: _____