INTAKE SHEET

DATE OF ACCIDENT: _____

Today's Date: _____ Referral Source: _____

BACKGROUND INFORMATION

Full Name: _____
First Middle Last

Other names known by (alias and maiden names):
_____ Email Address:_____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Office: _____ Other/Cell: _____

Date of Birth: _____ Social Security No.: _____/_____/_____

Place of Birth: _____

Age: _____ Weight: _____ Height: _____

Driver's License No. (including State): _____

Marital Status (Check One): ____ Married ____ Single ____Divorced
____ Separated ____Widowed/Widower

Spouse's Name: _____
First Middle Last

Former Spouses: Yes ____ No ____
If yes, list names, addresses, phone numbers and dates of marriage and divorce:

_____

_____

Children and/or other licensed household drivers (if not child, state relationship):

_____ _____
Name Age Name Age

_____ _____
Name Age Name Age

OCCUPATION

Employer: _____

Address: _____

Job Title: _____ How long employed? _____

Name of Supervisor: _____ Telephone: _____

Last date worked before illness/injury:
_____

Rate of Pay: _____ Per: Month _____ Week _____ Bimonthly _____

Date returned to work: _____

Did your job duties change after illness/injury? If yes, indicate how:
_____

_____

_____

Do you have income tax records for the last 5 years documenting your earnings for those years?

Yes ____ No ____

INCIDENT INFORMATION

Date of Accident: _____ Time: _____ SOL: _____

Location: _____ County: _____ City: _____

Weather Conditions: _____

Status: (e.g., driver, passenger, pedestrian, guest, customer, etc.); If passenger, who is driver?___

_____

Were police called? Yes ____ No ____ Agency (City Police, County Sheriff, State Trooper): __

_____

Was fire department called? Yes ____ No ____

Was ambulance called? Yes ____ No ____ Were you taken to hospital via ambulance? _____

List any citations given and to whom: _____

Do you have copy of accident/incident report?: Yes ____ No ____

Describe what happened: _____

_____

_____

_____

_____

Operation/Available Seatbelts? Yes☐ No☐ Seatbelts in use? Yes☐ No☐

Draw a diagram of accident scene:

Did you sign any papers for any insurance companies or give any verbal or written statements to any insurance companies? If so, please state to whom given: _____

Were any statements made by the other parties accepting fault for this accident? Yes __ No__

If yes, state the content of this statement and to whom it was made:

_____

_____

YOUR AUTOMOBILE INSURANCE INFORMATION

Name of your automobile insurance company:_____

Address: _____

Policyholder/Insured (If not you): _____

Policy Number: _____ Claim Number: _____

Adjuster's Name: _____ Phone Number: _____

Policy Limits: _____ PIP application completed? Yes ____ No ____

If you were either driving or a passenger in a vehicle not owned by you, please answer the following:

Name of vehicle owner: _____

Address of vehicle owner: _____

Vehicle owner's automobile insurance company: _____

Address of owner's automobile insurance company: _____

_____

Telephone No.: _____ Policy No.: _____

Claim No.: _____ Adjuster's Name: _____

DESCRIPTION OF VEHICLE INVOLVED IN CRASH

Vehicle (Year/Make/Model): _____

Plate Number (include State): _____

Describe damage to your vehicle: _____

Location of your vehicle: _____

Property damage resolved? Yes ____ No ____ Do you have a copy of the repair estimate? ____

Were Photographs taken? Yes ____ No ____ If so, by whom? _____

Please state location of damaged vehicle: _____

Have you reported the crash to your insurance company? Yes ___ No ____

WORKER'S COMPENSATION

Were you on the job at the time of the accident? Yes ____ No ____

Workers' Compensation carrier: _____

Address: _____

Insured: _____ Claim Number: _____

Adjuster's Name: _____ Phone Number: _____

Are you collecting any Worker's Compensation benefits because of your injuries related to this accident? Yes _____ No _____

HEALTH INSURANCE INFORMATION

Please list information on ALL health insurance policies available to you from the date of the accident until today, including group or individual, Medicare, Medicaid (all companies from which you get Medicaid benefits) and all supplemental health insurance policies covering you. If you have been covered (since the date of the accident) by more than three health insurance companies, please use the back of this form to write the additional information.

A. If you have had no health insurance coverage (from the date of the accident until today), please put "none" on line 1.

B. If you have Medicaid, please put WHY you qualify for this and list all Medicaid companies that you collect benefits from such as Florida Medicaid, Wellcare, Staywell, Medi Pass, Healthease, Amerigroup, United Health Care of Florida, etc. We need copies of all of the insurance cards from all of the companies you collect Medicaid benefits from.

C. If you have Medicare AND ARE NOT 65 YEARS OLD, please put WHY you qualify for this.

PLEASE PROVIDE US WITH A COPY OF ALL HEALTH INSURANCE CARDS. If you do not have all of your health insurance cards with you today, please bring the cards to our office so that photo copies can be made for our file.

(1) _____

Address: _____

Policyholder: _____ ID/Policy Number: _____

If Group Plan, employer of policyholder:_____

(2) _____

Address: _____

Policyholder: _____ ID/Policy Number: _____

If Group Plan, employer of policyholder:_____

(3) _____

Address: _____

Policyholder: _____ ID/Policy Number: _____

If Group Plan, employer of policyholder:_____

DISABILITY

Are you on Social Security Disability? Yes _____ No _____

If yes, do you get monthly benefits? Yes _____ No _____

AT-FAULT PARTY INFORMATION

Name: _____

Address: _____

Driver's License No. (include State): _____

Vehicle: _____ Plate Number: _____

Insurance Company: _____ Adjuster's Name: _____

Policy Number: _____ Claim Number: _____

Policy Limits: _____ Recorded statement given? Yes ____ No ____

Was there more than one at-fault party? If so, list immediately below

Name: _____

Address: _____

Driver's License No. (include State): _____

Vehicle: _____ Plate Number: _____

Insurance Company: _____ Adjuster's Name: _____

Policy Number: _____ Claim Number: _____

Policy Limits: _____ Recorded statement given? Yes ____ No ____

WITNESS INFORMATION

Names of any witnesses: (Please include addresses and telephone numbers, if known.)

_____

Name Address Telephone

_____

Name Address Telephone

INJURIES/MEDICAL TREATMENT

List all **PAIN** and **SYMPTOMS** you have felt from this accident (from your head to your toes):

_____

_____

_____

Have you sustained any visible bruises and/or scarring as a result of the accident?
YES _____ NO _____

List ALL health care providers you have treated with for this accident including ambulance, hospital, treating doctors, family doctors, chiropractors, neurologists, orthopaedists, MRI testing, physical therapy, massage therapy, CT scans, X-rays, etc.

Were you transported by ambulance? Yes _____ No _____

Name of Ambulance Company: _____

Name of hospital where you were initially treated: _____

Have you had any additional visits to any hospital for ER treatment or for outpatient testing?

Yes _____ No _____ Dates: _____

In sequential order, if possible, list all other health care providers you have treated with for this accident:_____

_____

_____

_____

_____

When are your next doctors' appointments?

Dr. Name: _____ Date: _____

Dr. Name: _____ Date: _____

PRIOR INJURIES AND MEDICAL TREATMENT

Describe in detail each and every **PAST** injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.) even if you sustained no injury and/or made no claim.

Motor vehicle accidents: _____

_____

Slip and fall/trip and fall accidents: _____

_____

Injuries that occur on the job: _____

_____

School and/or sport-related injuries: _____

_____

Other injuries or complaints: _____

_____

Name and address of family physician and/or primary care physician: _____

_____

Have you ever complained to or treated with any of the following **PRIOR TO** this accident?

1. Chiropractor: Yes _____ No ____ If so, with whom? _____
2. MRI facility: Yes _____ No ____ If so, where? _____
3. Orthopaedist: Yes _____ No ____ If so, with whom? _____
4. Other: _____

List every surgery you have had to date:

_____

_____

ADDITIONAL BACKGROUND INFORMATION

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons and results.

_____

_____

Have you ever been arrested? Yes ____ No ____

If yes, please provide the following information:

Date: _____ Charge: _____

Have you ever been convicted of a crime? Yes ____ No ____

If yes, please provide the following information:

Date: _____ Charge: _____

Date: _____ Charge: _____

Result (fine, penalty, probation, confinement, etc.): _____

_____

Do you currently have a bankruptcy case pending? Yes _____ No _____

If yes, please list the name and address of your bankruptcy attorney.

_____

Have you ever filed bankruptcy? Yes _____ No _____

If yes, please provide the following information:

Date: _____ Location: _____

PLEASE NOTE THAT THE FILING OF BANKRUPTCY DURING THE PENDENCY OF YOUR ACCIDENT CLAIM MAY ADVERSELY AFFECT YOUR CASE!

Have you ever been represented by any other attorney for any reason? Yes ____ No ____

Name: _____

Address: _____

Reason: _____

Give the names, addresses and telephone numbers of two people who will always know where to reach you:

Name	Address	Phone
Name	Address	Phone

tb/11/15/12