

FURR, HENSHAW & OHANESIAN

MYRTLE BEACH OFFICE: 1900 Oak Street, P.O. Box 2909, Myrtle Beach, SC 29578 (843) 626-7621
 COLUMBIA OFFICE: 1534 Blanding Street, Columbia, SC 29201 (803) 252-4050

PERSONAL INJURY INTAKE SHEET

PLAINTIFF INFORMATION

Client's Name: _____
 Street Address: _____
 P.O. Box or Apartment No.: _____
 City, State & Zip: _____
 Telephone w/area code: _____
 E-mail Address: _____

Birthdate/Place: _____ Social Security No _____

Married Single Divorced Separated Widowed

Spouse's Name: _____

Please list names, ages and addresses of all those (including children) who are dependent upon you for support, and your relationship to each:

Name	Age	Address	Relationship

Where did you hear about this firm:

If you are acting on behalf of a deceased relative, please list the names, addresses, telephone numbers and relationships to decedent of the decedent's immediate family: Date of death _____

Name	Age	Address	Relationship

EMPLOYMENT INFORMATION

Name of Employer (If unemployed, last employer): _____
 Address of employer: _____
 Telephone Number: _____
 Job Title and Type of Work: _____
 Names of Co-Workers: _____
 Present Rate of Pay: \$ _____ (per week/month/year) Hours worked each week: _____
 If regularly worked overtime, please indicate approximate amount of time and rate of pay: _____
 Do you receive tips or other type of income? _____
 When did you first begin working for your employer? _____
 If unemployed, when did you leave your employer? _____
 Reason for leaving: _____

What was your reported income the year before the accident? _____

CLAIMS AND LAWSUITS

Have you ever been involved in any claim or lawsuit, excluding divorce? _____ Yes _____ No

If so, list every claim you have made for money or lawsuits in which you have ever been involved:

Date: _____ Place: _____

Against Whom: _____

Nature of Claim: _____

Result: _____

Date: _____ Place: _____

Against Whom: _____

Nature of Claim: _____

Result: _____

INSURANCE INFORMATION

Do you have health or automobile insurance? _____ If so, please indicate:

Name of Health Insurance Company: _____

Policy No.: _____

Name of Party Covered: _____

Name of Automobile Insurance Company: _____

Street Address: _____

P.O. Box or Suite No.: _____

City, State, Zip: _____

Policy No.: _____

Policy Limits: _____

Type of Coverage: _____

MEDICAL HISTORY BEFORE ACCIDENT

Have you been hospitalized at any time before this accident? _____ If so, give reason:

Date	Name of Hospital and Doctor	Duration	Nature of Illness

Have you had any accidents or injuries before this accident? _____ If so, list below every such accident or injury and whether or not there was a claim for damages:

Date	Place	Nature of Accident/Injury	Name of Treating Physician	Claim?

Have you had any chronic illnesses or diseases before this accident? _____ If so, list them below:

Did you use any drugs or medication regularly before the accident? _____ If so, list the type of drug and reason for use:

Have you ever had any broken bones: _____ If so, give date and circumstances: _____

MILITARY BACKGROUND

Were you in the military service? _____ Dates: From _____ To _____
Type of discharge: _____ Branch of Service: _____

Any service-connected injuries? _____ If so, describe details: _____

POLICE RECORD

Have you ever been arrested? _____
If so, please list dates of arrest, place of arrest and charges _____

FACTS OF THE ACCIDENT

Date: _____ Time: _____
Describe what happened: _____

Were police called to the scene of the accident? _____ If so, did the police or anyone else take photographs of the accident scene? _____ If so, please provide the name of the police department or other person who has possession of such photographs: _____

To your knowledge, did anyone else investigate the accident or prepare an incident report? _____ If so:

Name of person who investigated the accident: _____
Name of investigator's employer: _____
Name of party possessing investigator's report: _____

FACTS CONCERNING THE DEFENDANT

Name and address of person (defendant) responsible for accident:

Full name of defendant: _____
Street address: _____
City, state, zip: _____
Defendant's insurance company: _____

Name of 2nd person (defendant) responsible for accident: _____
Street address: _____
City, state, zip: _____
Insurance company: _____

Please list information about any other persons responsible for accident on an attached sheet.

OTHER INJURED PARTIES

Were other parties, other than the defendant, injured in this accident? If so, please indicate the following:

Name of 2nd injured party: (2nd Plaintiff) _____
Street address: _____
City, state, zip: _____
Home telephone number: _____ Work number _____

Birthdate _____
 Type of injury: _____
 Relationship to you: _____
 Please list information about other injured parties on back.

WITNESSES TO THE ACCIDENT

List the names, addresses, and telephone numbers of all witnesses to the accident, including friends and neighbors, who may be of assistance in testifying about your case, your injuries, or changes in your activities since the accident:

Name of 1st witness: _____
 Address: _____
 Telephone: _____ Age: _____ Employment: _____
 Nature of testimony: _____

Name of 2nd witness: _____
 Address: _____
 Telephone: _____ Age: _____ Employment: _____
 Nature of testimony: _____

Name of 3rd witness: _____
 Address: _____
 Telephone: _____ Age: _____ Employment: _____
 Nature of testimony: _____

STATEMENTS MADE

Have you talked with any police officer, investigator, insurance adjuster or any other person about this incident? _____ If so, indicate to whom you have spoken, the person's address and telephone number:

Name	Address	Telephone

Have you given a written or recorded statement to any person about this incident? _____ If so, answer the following:

Name of person to whom statement was given: _____
 Date given: _____ If written, do you have a copy? _____
 Persons present at time: _____

Did you sign the statement? _____

Did the defendant make any statement to you or in your presence concerning this incident? _____
 If so, please indicate what was said and to whom: _____

When and where was the above statement made? _____

List the names and addresses of any persons who may have heard it:

Name: _____ Address: _____
 Name: _____ Address: _____

Were any statements about the accident made to or taken from anyone else at the scene of the accident? _____
 If so, please describe the name of the person from whom the statement was taken, as follows:

Name: _____

Address: _____ Telephone number: _____

Nature of statement: _____

DAMAGES FROM ACCIDENT

The amount of recovery made in this case will be affected by the injuries, damages or expenses incurred as a result of your accident. It is important that you fully list all information regarding your injuries and your expenses as a result of this accident.

State in full detail all injuries you received as a result of this accident:

Describe "loss of enjoyment of life" by listing below what normal activities, including sports, hobbies or other activities, you enjoyed before this accident and cannot do now as a result of the accident:

Activity	Number of times/week prior to accident	Number of times/week since accident

Have you missed time from work as a result of your injuries? _____ If so, please indicate the specific dates missed:

Did you lose wages for the periods of time missed from work due to this accident? _____
If so, state the total wages, including hourly rate: _____

Have you had any increases or decreases in your pay since the accident? _____ If so, explain:

If self-employed, have you had to hire anyone to take your place? _____ If so, please indicate the costs involved:

If you are a student, indicate time lost from school:

List all hospitals in which you were examined or treated or to which you were admitted as a patient as a result of the injuries sustained in this accident:

From/To	Name of Hospital	Address	Total Costs

List the full name, address and telephone number of each physician who has examined or treated you for your injuries:

Doctor's Name/Specialty	Address/Phone	Type of Treatment

Please state whether any physician recommended future surgeries or medical treatment for the injuries you sustained in this accident: _____ If so, list the physician name and type of treatment or surgery that may be required: _____

Have you used any of the following in connection with treatment?

Item	Dates From	Dates To
Wheelchair		
Back or neck brace/collar		
Crutches		
Traction		
Physical Therapy		
Other:		

Please list all medications which you have taken for injuries, the name of the doctor prescribing each medication and length of time you took the medication:

Type of Medication	Prescribing Doctor's Name	Length of time

Indicate the amount of all bills/expenses incurred to date as a result of this accident: \$ _____

PROPERTY DAMAGE (If applicable)

A copy of the declarations page of any automobile insurance policy covering the car in which you were riding at the time of the accident (whether you owned it or not), and in addition, any automobile insurance issued to you, or to any relative who was living with you at the time of the accident, regardless of whether these automobiles were involved in the accident.

Amount of property damage: _____

IMPORTANT

Please collect and attach copies of all medical and related bills incurred to date as a result of this accident, indicating which have been paid and which are still due. Please be sure to forward copies of all future medical bills, drug/medication bills, etc., as they are incurred, even if paid by insurance. See the following two pages for list of items to provide to your attorney and a list of general instructions that will require your attention.

In completing this intake sheet, have you thought of any information which we have not asked which may be of some assistance to us in representing you? If so, please state it on the back of this form no matter how silly, trivial or embarrassing it may seem.

Client's signature _____

Date _____

INSTRUCTIONS TO CLIENT

Please be sure to provide the following to your attorney:

1. All medical and hospital records;
2. Photographs (of scene of accident, of client showing injuries, braces, casts, etc., of damaged property);

3. All hospital, medical and related bills, either paid or unpaid (physicians, surgeons, ambulance, hospitals, private nursing care, therapy, drugs/medication, crutches, braces, x-rays, domestic help, car rental, clothing, etc.);
4. Income tax returns for the last five years;
5. Your health and automobile insurance policy or policies;
6. Insurance policy that may require aid of attorney to notify and collect (income protection, hospitalization, etc.);
7. Copies of any statements previously made to anyone (opposing side, your insurance carrier, etc.);
8. Repair bill on any damaged property;
9. Repair estimates on any damaged property;
10. Purchase invoices and estimates of value of personal property damaged or lost in accident (including clothing, jewelry, cameras, and all other property damaged in accident);
11. Correspondence with insurance company, insurance adjusters;
12. Copy of any accident reports; and
13. Statement from employer regarding lost wages showing time and wages lost from work.

PLEASE NOTE THE FOLLOWING GENERAL INSTRUCTIONS:

1. Do not talk to insurance adjuster;
2. Do not discuss the facts of the accident with anyone before having your first conference with the attorney;
3. Do not sign anything without your attorney's permission;
4. Keep a diary of your trips to all doctors, hospitals, therapists and notes of your pain with times and dates;
5. Keep all your medicine bottles and containers (as possible evidence at trial);
6. Bring or send all future medical bills to attorney's office;
7. When you return to treating physicians for follow-up examinations, be sure to advise them at each examination the nature of all of your continuing problems resulting from the accident;
8. Keep a record of all out-of-pocket expenses, including travel expenses for medical treatment;
9. Report to your attorney any suspicious actions, such as someone taking pictures, movies, etc.
10. Keep any braces or other devices you are required to wear as a result of your injuries.

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