FURR & HENSHAW

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and
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(803) 252-4050

FOR OFFICE USE ONLY**********************************
**********(File No.___________S/L __________________ Date File Opened ________________)*********
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CLIENT QUESTIONNAIRE

Note: If extra room is needed for answering any of the questions below, please attach sheet of paper to questionnaire with number of section you are answering

Date form completed ______________________

SECTION NO. 1

Victim's Full Name ____

Address __________________________________ County __________________________________

City ____State ______ Zip Code ______________

Telephone (home) ________________________ (work) ___________________________________
E-mail address ____
Social Security No. ____________ Date/Place of Birth ___________________________________

Employer ____

Employer's Address ____

Position Held ____

Name, address, and telephone number of person to contact in case of emergency:
____
____

Name of Victim's Spouse ___________________ Spouse's Date of Birth _____________________

Spouse's Social Security Number __________________ Date married _______________________

Spouse's telephone number (home) ______________________(work) _______________________

Spouse's employer & position held ____

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CHILDREN

Name	Age	Address

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SECTION NO. 2

(A) If the victim is deceased, has an estate been opened? If so, please attach a copy of the Certificate of Appointment showing who is responsible for the estate. Date of death _________

(B) If the victim was under 18 years of age, please complete the questions below

Father's name: ____
Mother's name: ____

If parents of minor are divorced or separated, list the custodial parent's name, address and phone number:

____

(C) If victim is incompetent to handle his/her own affairs, has someone been appointed guardian or conservator for the victim? If so, give name, address, and phone number of person appointed and send copies of documents showing the appointment.

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SECTION NO. 3

Have you conferred with any other attorney regarding your complaint of medical negligence?

Yes _______ No _______. If answer is yes, please state with whom you conferred and whether you have signed a fee contract with that attorney. ____

Where did you hear about this firm:
Attorney _________________________________ Friend ____________________
Yellow Pages _______Yes __________ No
If yes, which telephone book? ____
Other ____

Have you been involved in any previous lawsuits? Yes __________ No _________
If answer is yes, please state details: ____________________________________
____

Have you ever been arrested: Yes _________ No ________
If answer is yes, please state details: ____
____

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SECTION NO. 4

Date of incident which led you to believe medical negligence was committed: ______________________

What made you think the doctor, hospital employees or other health care providers may have been guilty of medical negligence?

____

____

____

List all doctors and/or hospitals who you feel committed medical negligence.

Name of Hospital or Doctor: ____

Address: ____

Dates of Treatment: ____

Reason for Treatment: ____

Complications: ____

Name Treated Under: ____

Date of Last Treatment: ____

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Name of Hospital or Doctor: ____

Address: ____

Dates of Treatment: ____

Reason for Treatment: ____

Complications: ____

Name Treated Under: ____

Date of Last Treatment: ____

Has any doctor, hospital employee or other health care provider told you there was negligence involved in the treatment? Yes ____________ No _________ If answer is yes, please state name, address and telephone number of person and the details of your conversation:

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SECTION NO. 5

List family members or friends who can furnish us information, which may be helpful in evaluating the case:

Name: ____________________

Address: ____________________

Telephone: (home) ______________ (work) ______________

Relationship to victim ____________________

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Name: ____________________

Address: ____________________

Telephone: (home) ______________ (work) ______________

Relationship to victim ____________________

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Name: ____________________

Address: ____________________

Telephone: (home) ______________ (work) ______________

Relationship to victim ____________________

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SECTION NO. 6

List all hospitals and doctors who treated the victim as a result of the negligence including the ones who may have committed negligence:

Name of Doctor or Hospital: ____________________

Address: ____________________

Date of Treatment: ____________________

Reason for Treatment: ____________________

Complications: ____________________

Name Treated Under: ____________________

Date of Last Treatment: ____________________

******

Name of Doctor or Hospital: ____

Address: ____

Date of Treatment: ____

Reason for Treatment: ____

Complications: ____

Name Treated Under: ____

Date of Last Treatment: ____

******

Name of Doctor or Hospital: ____

Address: ____

Date of Treatment: ____

Reason for Treatment: ____

Complications: ____

Name Treated Under: ____

Date of Last Treatment: ____

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SECTION NO. 7

Did medical insurance pay any of the medical bills?
Yes __________ No __________ If yes, please state name and address of company:

____

____

What are the approximate total medical bills as a result of the negligence?

$ __________________________

Did the victim miss any work as a result of the medical negligence? If answer is yes, total amount of lost wages.

____

List any other expenses or damages as a result of the alleged medical negligence.

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SECTION NO. 8

Is there any other information you feel we need to know to assist us in evaluating the medical negligence case? If answer is yes, please state details: ____

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SECTION NO. 9

WRITE A COMPLETE STATEMENT OF ALL THAT HAPPENED THAT MAKES YOU FEEL THERE MAY HAVE BEEN NEGLIGENCE. PLEASE INCLUDE A STATEMENT OF HOW THE INJURY HAS AFFECTED THE VICTIM AND HIS/HER FAMILY. BE AS COMPLETE AS POSSIBLE.

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SECTION NO. 10

PLEASE PLACE AN “X” BELOW SHOWING HOW YOU WOULD LIKE TO HAVE YOUR REVIEW DONE.

_______I CHOOSE to have an internal review of my file done at Furr & Henshaw, as time permits.

_______I CHOOSE to have a review of my file done by a medical expert as soon as possible and I am enclosing my check in the amount of $2,000.00 to expedite my records to the expert.