

The Foust Firm, PLLC
Jeffrey B. Foust
817-912-0722

SOL: _____

**PERSONAL INJURY/AUTO ACCIDENT
INTAKE SHEET**

INITIAL CLIENT STATEMENT

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE? _____

IF SO, PLEASE GIVE NAME OF ATTORNEY: _____

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? _____

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)

PERSONAL INFORMATION:

NAME: _____

Address: _____

Telephone Number: (home and cell) _____

E-mail address: _____

Age: ___ Date of Birth: _____ Social Security No: _____

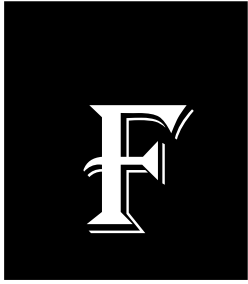
EMPLOYER: _____

Address: _____

Telephone Number: (work) _____

Occupation: _____ Worked there how long? _____

Immediate Supervisor: _____



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SPOUSE'S NAME: _____

Address: _____

Telephone Number: (home) _____

Spouse's Employer: _____

Employer's Address: _____

Telephone Number: (work) _____ Occupation: _____

Age: ___ Date of Birth: _____ Social Security No: _____

CHILDREN:

Name(s)/Age(s): _____

How many children are living with you now? _____

EMERGENCY CONTACT:

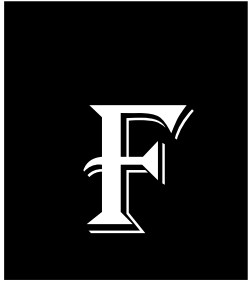
Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____



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EDUCATION:

High School/G.E.D.: _____ Year of Graduation: _____

Technical School: _____

College/University: _____ Years & Degree: _____

EMPLOYMENT HISTORY:

Employer: _____ Position: _____

Duties: _____

Employer: _____ Position: _____

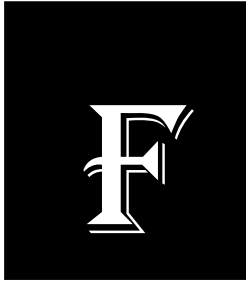
Duties: _____

Employer: _____ Position: _____

Duties: _____

Employer: _____ Position: _____

Duties: _____



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Prior **similar injuries**, treated medical conditions and/or symptoms

to same area or current injury (Dates/Drs.): _____

Prior **claims and/or settlements** (types, dates, attorneys):

List any **prior injury settlements**: _____

ACCIDENT INFORMATION:

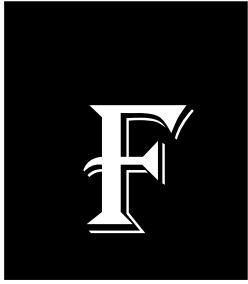
Accident Date: _____ Date of Week: _____

Time: _____ am/pm

Location: (Be Specific) _____

Where were you coming from? _____

Where were you going? _____



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DETAILS OF ACCIDENT:

Weather condition (if happened outside): _____

Any construction in the area? _____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC-- GET AS MUCH DETAIL AS POSSIBLE) _____

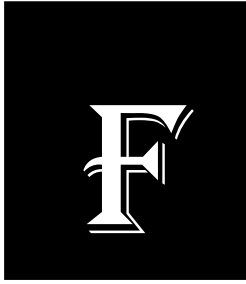
(Description of accident continued)

Did this injury occur when you were driving a vehicle? _____

Were you driving a company vehicle? _____

What was the make, model and year of the vehicle you were driving? _____

What was the make, model and year of the other vehicle? _____



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Was anyone, including yourself, to the best of your knowledge, taking any medication or using any sort of drugs? _____

Had anyone, including yourself, been drinking? _____

Did anyone make a statement at the scene? _____

Who made such a statement, if any? _____

What was said? _____

To whom? _____

Were photographs taken of the scene? _____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: _____

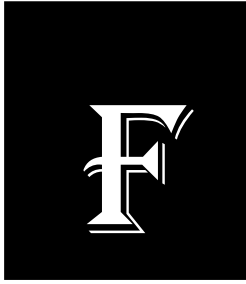
Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

Collision coverage amount: _____

Deductible Amount: _____



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Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Cash Policy for Accidents: _____

Effective Dates of coverage: _____

Is this a WORKER'S COMP CLAIM? _____

Are you covered through your employer's insurance? _____

If so, provide company and agent, if known: _____

Policy or plan number: _____

Name of insured: _____

Limits of coverage: _____

Did you file a claim with your insurance company? _____

Has anyone from the insurance company contacted you about this claim? _____

Name of Person who contacted you: _____

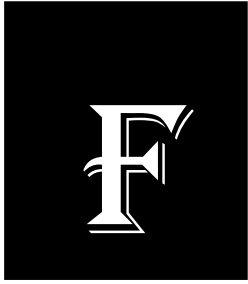
When was contact made? _____

If a statement was given, was it tape recorded or written?

Did you receive a copy? _____

Have you signed any authorizations to release information to anyone? _____

If so, identify: _____



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Have you signed any releases? _____

If so, for whom? _____

Have you received any insurance benefits? _____

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? _____

If so, which agency? _____

INSURANCE COVERAGE FOR DEFENDANT:

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

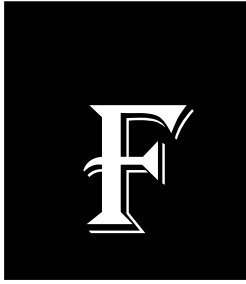
Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____



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MEDICAL INFORMATION:

Were you injured in this accident? ____ Describe: _____

Did you go to the hospital? _____

Which hospital _____

Admitted or Out Patient? _____

If admitted, release date: _____

X-Rays taken? _____ Were you taken by ambulance? _____

Are you under the care of a physician now? _____

LIST DOCTORS:

1. Name: _____ Phone: _____

Address: _____

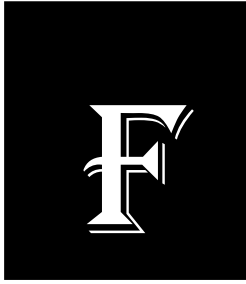
Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____



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2. Name: _____ Phone: _____

Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

3. Name: _____ Phone: _____

Address: _____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

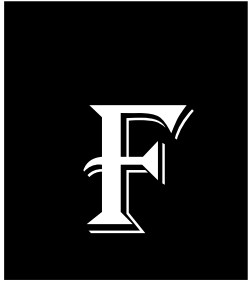
Physical therapy? _____

Current Balance on Medical Bills: _____

4. Name: _____ Phone: _____

Address: _____

Telephone Number: _____



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When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

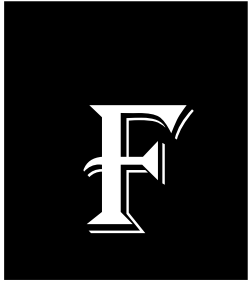
PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR, CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING, OR WHEN CAST IS REMOVED.

Was anyone else injured? _____

Who was injured? _____

Describe Injury: _____

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:



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WITNESSES:

1. NAME & ADDRESS: _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.):

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

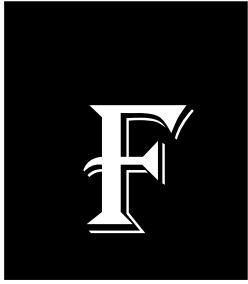
2. NAME & ADDRESS : _____

Telephone Number: (____) _____

Relationship (fellow employees, supervisors, bystanders, etc.):

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____



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VIEWING THE SCENE:

Can we go to the accident scene? _____

Is the equipment available for inspection? _____

Who do we contact to arrange a viewing? _____

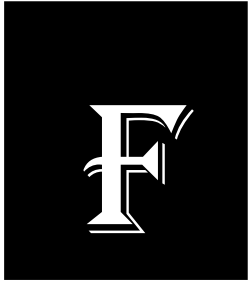
NAME & ADDRESS: _____

Telephone Number: (____) _____

Job Title: _____

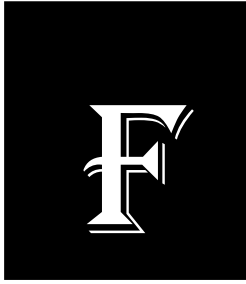
Can we photograph the equipment? _____

Any other information you feel may assist us in representing you for this claim? _____



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DIAGRAM OF HOW ACCIDENT OCCURRED:



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DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): ____

Sports: _____

Social Activities: _____

Job Duties: _____

Household Chores: _____

Have you had to hire domestic help? _____

How do you feel you have been damaged emotionally by these injuries? _____

How do you feel you have been damaged financially by these injuries? _____
