WEISBERG & ASSOCIATES
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PERSONAL INFORMATION

Client's Name _____
Date _____
Address _____
Phone H _____ W _____
SSN _____ Race _____ Sex _____
Age _____ DOB _____
Marital Status ☐ M ☐ S ☐ D
Resides With _____

EMPLOYMENT INFORMATION

Name of employer (if unemployed, last employer) _____
Address of employer _____
Telephone number _____
Personnel Director/Supervisor _____
Job title/type of work _____
Present rate of pay $ _____ Per ☐ Week ☐ Month ☐ Year
Hours worked each week _____ Do you regularly work overtime? ☐ Yes ☐ No
If so, indicate approximate amount of time & rate of pay Hours _____ Rate of Pay _____
Do you receive tips or other type of income? ☐ Yes ☐ No If so, indicate

Type of income	Amount	Per week/month/year
_____	$ _____	_____
_____	$ _____	_____
_____	$ _____	_____
_____	$ _____	_____

When did you first begin working for this employer? _____
If unemployed, when did you leave this employer? _____
Reason for leaving _____
What was your reported income in the year before your accident? $ _____
Were you working for your employer at the time the injury occurred? ☐ Yes ☐ No
Did you apply for worker's compensation benefits because of your accident? ☐ Yes ☐ No

If so, indicate the amounts paid to or received by you to date $ _____

CRIMINAL HISTORY

Have you ever been convicted of a felony? ☐ Yes ☐ No If so, describe as follows
Place _____
Charge _____
Result _____
Date of conviction _____

Place _____
Charge _____
Result _____
Date of conviction _____

Is there now, or has there ever been, a restriction on your driver's license? ☐ Yes ☐ No
If so, describe the details of such restriction _____

CLAIMS AND LAWSUITS

Have you ever been involved in any claim or lawsuit, excluding divorce? ☐ Yes ☐ No
If so, list below every claim you have made for money or lawsuits in which you have ever been involved
Date _____ Place _____
Against whom _____
Nature of claim _____
Result _____

INSURANCE INFORMATION

Name of insurance company _____
Address _____
Adjuster's name _____ Telephone _____
Policy number _____ Policy limits $ _____
Do you have insurance covering damage to your car? ☐ Yes ☐ No
Deductible amount $ _____
How much does your insurance cover if you hurt someone else with your car? $ _____
Uninsured motorist policy limits $ _____ Med Pay Amount $ _____

Do you have a second uninsured motorist policy? ☐ Yes ☐ No If so, fill in the following
Name of second insurance company _____
Address _____
Adjuster's name _____ Telephone _____
Policy number Policy limits $

Do you have health or accident insurance? ☐ Yes ☐ No If so, indicate
Name of health insurance company _____
Policy # _____
Address _____
Insurance agent's name _____ Telephone _____

Name of accident insurance company _____
Policy # _____
Address _____
Insurance agent's name Telephone

Have you ever had insurance of any kind declined or cancelled? ☐ Yes ☐ No
If so, give reason _____

MEDICAL HISTORY BEFORE ACCIDENT
Have you been hospitalized at any time before this accident? ☐ Yes ☐ No
If so, list below all hospitalizations

Date	Name of Hospital and Doctor	Duration	Nature of illness

Have you had any physical examinations before this accident? ☐ Yes ☐ No
If so, list below all physical examinations for five years before this accident.

Date	Name of Doctor and Address	Purpose

Have you had any accidents or injuries before this accident? ☐ Yes ☐ No

If so, list below every such accident or injury and whether there was a claim for damages or not.

Date _____ Place _____
Nature of accident/injury _____
Name of treating physician _____
Claim? ☐ Yes ☐ No

Date _____ Place _____
Nature of accident/injury _____
Name of treating physician _____
Claim? ☐ Yes ☐ No

Have you had any chronic illnesses or diseases before this accident? ☐ Yes ☐ No
If so, list every such illness or disease suffered in the five years before this accident

_____
_____

Have you had any other chronic health problems or disabilities? ☐ Yes ☐ No
If so, list them below

_____
_____

Did you use any drugs or medication regularly before the accident? ☐ Yes ☐ No
If so, list the type of drug and reason for use

_____
_____

Have you ever had any broken bones? ☐ Yes ☐ No
If so, give date and circumstances

Date	Circumstances
_____	_____
_____	_____

FACTS OF THE ACCIDENT
Date _____ Day _____ Time _____
Weather conditions _____
Were seat belts in use in your vehicle? ☐ Yes ☐ No
If so, who in your vehicle was using a seat belt and who was not using a seat belt?
Were police called to the scene of the accident? ☐ Yes ☐ No
If so, did the police take photographs of the accident scene? ☐ Yes ☐ No
If so, which police department has possession of such photographs? _____

Describe what happened

FACTS CONCERNING THE DEFENDANT - (person responsible for accident)

Full name of defendant
Address
Name of defendant's employer
Name of defendant's spouse

Name of defendant's insurance company
Address
Adjuster's name Phone
Policy No. Claim No. Policy limits $

Do you know what the defendant's financial circumstances are, excluding any insurance coverage?
If so, specify

Give your observations about the defendant as a person

Name of 2nd person responsible for accident
Address
Name of 2nd person's insurance company
Address
Adjuster's name Phone
Policy No. Claim No. Policy limits $

OTHER INJURED PARTIES

Were other parties, other than the defendant, injured in this accident? ☐ Yes ☐ No

If so, indicate the following

Name of 2nd injured party: (2nd plaintiff)
Address
Relationship to you Telephone number Birthdate

Name of 3rd injured party: (3rd plaintiff)
Address
Relationship to you Telephone number Birthdate

WITNESSES TO THE ACCIDENT

List the names, addresses, and telephone numbers of all witnesses to the accident, and any other persons 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 _____

STATEMENTS MADE

Have you talked with any police officer, investigator, insurance adjuster or any other person about this incident? ☐ Yes ☐ No 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?

☐ Yes ☐ No If so, answer the following

Name of person to whom statement was given _____

Date given _____ If written, do you have a copy? ☐ Yes ☐ No

Persons present at time _____

_____

Did you sign the statement? ☐ Yes ☐ No

Did the defendant make any statement to you or in your presence concerning this incident?

☐ Yes ☐ No If so, indicate what was said and to whom _____

_____

When and where was the above statement made?

Date _____ Place _____

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

Name	Address

Were any statements about the accident made to or taken from anyone else at the scene of the accident? ☐ Yes ☐ No

If so, describe the name of the person from whom the statement was taken, as follows

Name _____ Telephone number _____

Nature of statement _____

Were any statements about the accident made to or taken from anyone else at the scene of the accident? ☐ Yes ☐ No

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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: _____

State your present physical condition such as scars, deformities, headaches, etc.

Describe "loss of enjoyment of life" by listing 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	Times/week prior to accident	Times/week after accident

Have you missed time from work as a result of your injuries? ☐ Yes ☐ No

If so, indicate the following

From To

Did you lose wages for the periods of time missed from work due to this accident?

☐ Yes ☐ No If so, state the total wages lost to date and the dates

Wages lost Dates

Have you had any increases or decreases in your pay since the accident? ☐ Yes ☐ No

If so, explain

Did you lose any promotion or merit increase or fringe benefits due to the accident?

☐ Yes ☐ No If so, describe

If self employed, have you had to hire anyone to take your place? ☐ Yes ☐ No

If so, indicate the costs involved

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

From To

Indicate period of time you were confined to your home:

From To

Indicate period of time you were confined to bed rest:

From To

When is it expected you can return to work?

List any non-monetary compensation you have lost

Have you been forced to borrow any money as a result of your injuries and inability to work?
☐ Yes ☐ No If so, describe _____

_____

_____

Are you able to work part time? ☐ Yes ☐ No
If so, where or what kind of work could you do? _____

_____

_____

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
Name of hospital
Address
From _____ To _____
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 _____ Telephone _____
Address _____
Specialty _____
Type of treatment _____

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

	Dates From	To
Wheelchair		
Back or neck brace/collar		
Crutches		
Traction		
Physical therapy		
Other		

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 (attach copies of all such bills, whether paid or unpaid.) $ _____

Have you sustained any other injuries since this accident? ☐ Yes ☐ No
If so, indicate date, nature of injury and whether you received medical treatment for said injuries

Date of injury	Nature of injury	Medical treatment

PROPERTY DAMAGE

If your vehicle was damaged and has been repaired, indicate name and address of party who made repairs
Name of Person who performed repairs _____
Address _____ Telephone number _____
Have you incurred car rental expenses? ☐ Yes ☐ No Total Rental Expense $ _____
Where is your vehicle presently located? _____
If any other personal property was damaged, describe said property

_____

_____

Total medical & related expenses to date $ _____ Date _____
Total of property damage amount to date $ _____ Date _____

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 I have not asked which may be of some assistance to me in representing you? If so, state it on the back of this form no matter how silly, trivial or embarrassing it may seem.

_____
Client's signature

_____
Date