CLIENT INFORMATION SHEET

The information you give us on this form is very important. It will help us investigate your accident and determine how to best proceed with your case. If you don't have all the information we ask for in this form, please let us know so we can help you get it. **All of your answers will be kept strictly confidential.**

Today's date: _____

How were you referred to **The Law Offices of Dianne L. Sawaya, LLC**?

_____

PERSONAL INFORMATION

Name: _____

Date of birth: _____ Social Security No._____

Address: _____ Apt.: _____

City: _____ State: _____ ZIP : _____

Telephone no.: (Home) _____ (Work) _____

(Cell) _____

May we have permission to communicate via text message with you? Yes☐ No☐

Do you have a ***Facebook*** page? Yes ☐ No ☐ **(Please review the handout on the Dos & Don'ts of social networking)** E-mail: _____

Would you like our *electronic client newsletter* sent to your email address? Yes ☐

No☐

Height: _____ Weight: _____ Are you: Right-handed ☐ Left-handed: ☐

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's name: _____ Spouse's phone no.: _____

Dependents and ages: _____

_____

Your driver's license: No. _____ Exp. date: _____

******IMPORTANT INFORMATION******

Please list the name of a relative or friend who does not live with you: (for contact in an emergency

and we can't reach you)

Name: _____ Phone no.: _____

INFORMATION ON THE ACCIDENT

Date: _____ Time: _____ Location: _____

Did an ambulance come to the scene? Yes ☐ No ☐ Name:
_____

Were you transported to the hospital? Yes ☐ No ☐ Name: _____

Were there other people in the accident? Yes ☐ No ☐ Were they injured? Yes ☐ No ☐

Were any of them transported to the hospital? Yes ☐ No ☐

Were police notified? Yes ☐ No ☐ Did the police investigate the accident? Yes ☐ No ☐

Which police department/city? _____
Case: _____

Did you make any statements to anyone at the scene? Yes ☐ No ☐

To whom: _____

What did you say?

Did anyone make any statements to you at the scene? Yes ☐ No ☐

Who made the statements? _____

What did they say?

_____

_____

Were you on the clock? Yes ☐ No ☐

What were you doing at the time of the accident?

_____

Describe what happened how were you injured?

_____

_____

_____

Please list any PAST motor vehicle accidents you've been in, any Worker's Compensation claims you have filed, or claims of any other sort you've made (Date of incident, type of injuries, financial awards received):

_____

_____

_____

Do you have any **prior** injuries to the same or similar body parts that have been **re-injured** in this accident? Yes ☐ No ☐ If so, please describe:

_____

_____

INFORMATION ON WITNESSES

Were there any witnesses to the accident? Yes ☐ No ☐

Please list witnesses, including all people inside the car you were in and where they were sitting, and anyone who witnessed the accident from outside the car. In a brief sentence tell what they would be able to say for you and how they could explain how your injuries have affected you.

Name: _____ Phone no.: _____

Name: _____ Phone no.: _____

Name: _____ Phone no.: _____

INSURANCE INFORMATION

Have you notified your employer of the accident? Yes ☐ No ☐ When?_____

Who did you report the injury to? _____

How? _____

Have you been contacted by your Employer's W/C insurance company? Yes ☐ No ☐

Name of your Employer's Workers' Comp insurance company: _____
_____

Div of W/C Claim #: _____ Insurance Claim #: _____

Name of your agent or adjuster? _____

Have you received any letters from **any** insurance company or Div of W/C asking question about this accident? Yes ☐ No ☐
Have you received any documents from your employer, insurance company or Division of W/C? Such as notice of contest, general admission of liability, final admission of liability?)
Yes ☐ No ☐ If so, when? _____

Has anyone taken your recorded statement? Yes ☐ No ☐

If so, who took it? _____ When? _____

Do you have **HEALTH INSURANCE***? Yes ☐ No ☐

Name of Insurance Company:
_____

Insurer contact: _____ Phone no.: _____

Group/policy no.: _____ Member no.: _____

Does **MEDICARE*** pay any of your medical bills? Yes ☐ No ☐

Does **MEDICAID*** pay any of your medical bills? Yes ☐ No ☐

If yes, what is your Medicare/Medicaid no.:
_____

Are you eligible to receive treatment at a VA hospital? Yes ☐ No ☐

Do you receive Social Security? Yes ☐ No ☐ If yes: SSD ☐ SSI ☐

Please provide a copy of ALL Health Insurance Cards- including your Medicare/Medicaid card.

INFORMATION ABOUT YOUR WORK

Employer's name: _____

Employer's address: _____

City: _____ State: _____ ZIP : _____ Phone: _____

What is your occupation? _____

Period of employment: Start date _____ End date (if applicable) _____

Income at the time of the accident: $_____ per _____

Any other income (commissions, bonuses, second job etc.): $_____

Income now: $_____ per _____

Any other income (commissions, bonuses, second job etc.): $_____

Prior Employer(s) within the 12 months? _____

Income from that position: $_____ per _____

Has this accident affected your ability to do your job? Yes ☐ No ☐

As a result of this accident, have you missed any time from work? Yes ☐ No ☐

How many days? _____ Are you working now? Yes ☐ No ☐

Have you received compensation for days missed? Yes ☐ No ☐ If so, how? _____

Are you receiving any other non-W/C insurance? Yes ☐ No ☐

For how many days so far: _____

Name of the doctor who told you not to work: _____

Doctor's address:

_____

City: _____ State: _____ ZIP : _____ Phone: _____

INFORMATION ABOUT YOUR INJURIES

Please list any medical complaints or symptoms you think may have been caused by the accident:

_____

_____

_____

_____

Please describe any bruises, cuts or other visible injuries that were caused by the accident (for example, bruises or cuts from the seat belt):

_____

_____

Did you hit your head on anything in the accident? Yes ☐ No ☐

Please describe: _____

Did you lose consciousness? Yes ☐ No ☐ For how long? _____

If you don't think you lost consciousness, is there anything about the accident you don't recall (such as time of the accident, taking off your seat belt)? Yes ☐ No ☐

If yes, please describe:

_____

_____

_____

Please list the names of all medical facilities you've been to since the time of the accident.

FACILITIES	FULL NAME	PHONE NUMBER/ADDRESS
Emergency department:		
Hospital		
Imaging center (X-rays, MRI etc.)		
Walk-in clinic:		
Doctor:		
Chiropractor:		
Physical therapist:		
Other:		

Did your employer or W/C insurance company tell you where to seek treatment? Yes ☐ No ☐

Did they give you a document noting providers you can treat with? Yes ☐ No ☐

Has your treatment received been paid for? Yes ☐ No ☐

Do you have any outstanding bills? Yes ☐ No ☐

****

Have your eyes hurt since the time of the accident? Yes ☐ No ☐

Have your ears hurt, seemed stuffy or had ringing in them? Yes ☐ No ☐

Have you had dizzy spells or a feeling the room is spinning? Yes ☐ No ☐

Have you had pain or stiffness in your jaw since the accident? Yes ☐ No ☐

Have you noticed a "click" or catch in your jaw since the accident? Yes ☐ No ☐

Have you had headaches as a result of the accident? Yes ☐ No ☐
Please describe the headaches (dull or sharp, location, how often, how long):

_____

How often do you get these headaches? _____

How long do these headaches last? _____

Does your back hurt as a result of the accident? Yes ☐ No ☐

What part of your back? _____

How often does your back hurt? _____

Does your neck hurt as a result of the accident? Yes ☐ No ☐

Have you noticed a "clunk" or grinding sound in your neck? Yes ☐ No ☐

How often does your neck hurt? _____

Have you had any pain in your arms or legs since the accident? Yes ☐ No ☐

Where is the pain?
_____

Have your arms or legs been numb since the accident? Yes ☐ No ☐

Where? _____

Since the accident, have you had problems with any of the following?

Loss of sense of smell	Yes ☐ No ☐
Change in your sense of smell	Yes ☐ No ☐
Changes in vision	Yes ☐ No ☐

Changes in hearing	Yes ☐ No ☐
Muscle weakness	Yes ☐ No ☐
Trouble walking	Yes ☐ No ☐
Problems dropping things	Yes ☐ No ☐
"Pins and needles" sensations	Yes ☐ No ☐
Coordination problems	Yes ☐ No ☐
Balance problems	Yes ☐ No ☐
Tremors or shakiness	Yes ☐ No ☐
Dizziness	Yes ☐ No ☐
Vomiting	Yes ☐ No ☐
Blackout spells	Yes ☐ No ☐
Fainting spells	Yes ☐ No ☐
Seizures or fits	Yes ☐ No ☐
Periods where you lose time	Yes ☐ No ☐
Feelings of being in a daze	Yes ☐ No ☐
Hallucinations	Yes ☐ No ☐
Illusions:	Yes ☐ No ☐
Changes in appetite, either more or less	Yes ☐ No ☐

Have you ever had or been diagnosed as having any of the following?

Serious infections	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐
Liver problems	Yes ☐ No ☐
Kidney problems	Yes ☐ No ☐
Problems with arteries	Yes ☐ No ☐
Stroke	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐
Heart problems	Yes ☐ No ☐
Blood problems	Yes ☐ No ☐
Cancer	Yes ☐ No ☐

Please list any surgeries you have had before the accident.

Date	Surgery	Doctor	Hospital
_____	_____	_____	_____
_____	_____	_____	_____

OTHER AREAS AFFECTED BY THE ACCIDENT

Since the accident, have you continued to do activities around the house, even though they're more difficult or cause you pain? Yes ☐ No ☐

Since the accident, have you stopped doing things you used to enjoy (such as sports, gardening, travel) because they're more difficult or cause you pain? Yes ☐ No ☐

What are you not able to do anymore because of the accident? _____

Since the accident, have you had problems with any of the following?

Flashbacks to the accident?	Yes ☐	No ☐
Nightmares?	Yes ☐	No ☐
Intrusive thoughts?	Yes ☐	No ☐
Fear or uneasiness about driving?	Yes ☐	No ☐

Since the accident, has your sex drive changed? Yes ☐ No ☐ If so, is it: More ☐ Less ☐

Since the accident, have you had problems with:

Stress, tension or tense muscles	Yes ☐	No ☐
Anger or keeping your temper	Yes ☐	No ☐
Controlling your actions	Yes ☐	No ☐

Since the accident, do you have:

Physical fatigue	Yes ☐	No ☐
Sleep disturbances	Yes ☐	No ☐
Trouble falling asleep or staying asleep	Yes ☐	No ☐
Trouble waking up too early	Yes ☐	No ☐
Tendency to sleep at abnormal times	Yes ☐	No ☐

Do you drink alcohol? Yes ☐ No ☐ How many drinks per day? _____

Is this more or less than before the accident? More ☐ Less ☐ Same ☐

Do you use drugs recreationally? Yes ☐ No ☐ What drugs do you use? _____

Is this more or less than before the accident? More ☐ Less ☐ Same ☐

Have you ever been addicted to any drugs? Yes ☐ No ☐ What drugs? _____

Since the accident, have you had trouble with any of the following?

Using tools	Yes ☐	No ☐
Telling right from left	Yes ☐	No ☐
Getting dressed	Yes ☐	No ☐
Remembering things	Yes ☐	No ☐
Understanding others	Yes ☐	No ☐
Following a conversation	Yes ☐	No ☐
Speech	Yes ☐	No ☐
Reading	Yes ☐	No ☐
Writing	Yes ☐	No ☐

Since the accident, do you:

Get lost often	Yes ☐	No ☐
Forget where you are	Yes ☐	No ☐
Forget the time and day	Yes ☐	No ☐

Forget meetings and appointments Yes ☐ No ☐

Since the accident, does it seem that you:

Can't think as quickly anymore Yes ☐ No ☐
Find it hard to think clearly Yes ☐ No ☐
Are more easily distracted Yes ☐ No ☐
Have trouble with "common sense" Yes ☐ No ☐
Become confused easily Yes ☐ No ☐
Can't plan activities as well as before Yes ☐ No ☐
Can't learn new things Yes ☐ No ☐
Have difficulty with new situations Yes ☐ No ☐

Since the accident, do you:

Hear unusual sounds Yes ☐ No ☐
See unusual things Yes ☐ No ☐
Have strange feelings Yes ☐ No ☐
Have bizarre thoughts Yes ☐ No ☐
Think about suicide Yes ☐ No ☐
Tried to commit suicide Yes ☐ No ☐
Plan to commit suicide Yes ☐ No ☐
Have new phobias Yes ☐ No ☐

Since the accident, have you felt:

Depressed or down in the dumps Yes ☐ No ☐
Anxious or had panic attacks Yes ☐ No ☐
Preoccupied with yourself Yes ☐ No ☐
Impulsive Yes ☐ No ☐
A need for immediate gratification Yes ☐ No ☐
Alienated from others Yes ☐ No ☐
Anti-social Yes ☐ No ☐
Uncooperative Yes ☐ No ☐
Apathetic or withdrawn from others Yes ☐ No ☐
Obsessed about things: Yes ☐ No ☐

Have you suffered a head injury in the past? Yes ☐ No ☐

If yes, please describe when and how it happened:

_____

_____

_____

Is there anything else you can think of that we should know?

_____

_____

_____

_____

_____

_____

Thank you for taking your time to fill out this form. Even though it was time-consuming, it provides us with valuable information that we need to properly take care of your case. Please be assured that **we will keep this information strictly confidential** *and will not release it to anyone outside The Law Offices of Dianne L. Sawaya, unless you tell us to or give us permission to as part of your case, or as may be required by law.*