FARRAR LAW FIRM
Your Pensacola Legal Advisor

109 N. Palafox Street
Pensacola, Florida 32502

Telephone (850) 434-8904
Fax (850) 434-8922

PREFACE

Answer every question **FULLY AND ACCURATELY**. Success in this case depends upon mutual confidence and complete cooperation between client and attorney. It is imperative that your attorney know as much or more about you, your history and your activities, than the defendant **WILL KNOW** by the time your case goes to trial. You **MUST ASSUME** that the defendant will then know much about you.

ONE SURPRISE at the trial, produced on your attorney by the defendant because of an incorrect answer here, **CAN RUIN YOUR CASE**. Do not fail to answer a question fully, even though it may be embarrassing or you do not think it is important or you cannot understand why it has anything to do with your case.

This questionnaire is divided into major headings. Although it may appear long and complicated, each question has some importance to your case. In each instance we have provided space for you to fill in the answer. The success of your case will be governed by your cooperation. Please contact us at our office if you have any questions (850) 434-8904.

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CLIENT QUESTIONNAIRE FORM

GENERAL INFORMATION

1. Full name: _____

   Present address: _____
   _____
   Home Telephone: _____ Work Telephone: _____
   Cellular: _____
   Email: _____
   Marital Status: _____
   If you have no phone, where can you be reached by telephone?_____
   Date of Birth: _____ SSN: _____
   Driver's License Number: _____
   Height: _____ Present Weight: _____ Normal Weight: _____

2. List here the addresses where you have resided during the past ten years, and give the period of time at each residence, including dates.

   _____
   _____
   _____

   _____
   _____
   _____

   _____
   _____
   _____

   _____
   _____
   _____

3. Have you ever used, or been known by any other name than that shown above?_____

   If so, list here each such other name, and state when and why you used such other name.

4. Where were you born? _____

   a. Have you ever used any birth date or birthplace other than shown above? _____

   b. If so, list here each such other birth date or birthplace, and state when and why you used each:

   _____
   _____

   _____
   _____

   _____
   _____

5. Are you married at the present time? _____
   If so, what is the full name of your spouse? _____

6. List the names, ages and addresses of all children and any other persons who may be dependent upon your support.

NAME	AGE	ADDRESS

7. Are you and your spouse living together at the present time? _____

8. Have you been divorced, or legally separated, at any time? _____

   If so, from whom, when and where? _____
   _____
   _____
   _____

9. Have you ever hired an attorney before? Yes _____ No _____

   If yes, name and for what purpose: _____
   _____
   _____

10. List the name, address, relationship, and telephone number of your closest relatives and closest friends.

NAME	RELATIONSHIP	ADDRESS

11. Claims and Lawsuits: Any lawyer knows that there have been many cases damaged beyond repair by a history of other claims and lawsuits which he did not know about. List here EVERY claim you have ever made for personal injury or property damage, and fill in the details.

AGAINST WHOM	DATE	NATURE OF CLAIM	SUITE FILED

12. Police Record: The defense will make a complete investigation of your background, and we must be PREPARED AGAINST development of unfavorable evidence. List here every arrest and state the date, place, charge and result.

PLACE	DATE	CHARGES	RESULT	CONFINED

13. Are you currently receiving any disability benefits or payments such as SSI, social security disability, workers compensation benefits, or payments from a disability policy from your place of employment or any other type of disability policy? _____

_____

If so, please list the source of payment and the amount you receive per month.

SOURCE	AMOUNT

INSURANCE INFORMATION

1. List all automobile insurance companies which may provide coverage for this accident:

NAME OF INSURED	INSURANCE COMPANY	POLICY PERIOD

2. List all residents of your household at the time of the accident, including any relatives who may have left home to attend school, military service, or were in your household on a temporary basis.

_____
_____
_____
_____

3. List the name of all health insurance carriers which may provide medical payments coverage, group medical, or disability insurance for the injuries received in this accident.

NAME OF CARRIER	ADDRESS	GROUP/PLAN NO.

4. Are you a Medicare recipient? _____ Medicaid? _____

WORK BACKGROUND

The amount of your recovery in this case will be affected by loss of earnings and earning capacity, so please outline carefully your work background.

1. Were you employed at the time of the accident? _____

If so, state the name, address and telephone number of your employer.

_____
_____

2. What was your job title, or the type of work you were doing? _____
_____
_____

3. What was your rate of pay? _____

4. How many hours per week were you working regularly immediately prior to the accident? _____

5. When were you first employed by the company for which you were working at the time of the accident? _____

6. Have you remained in the same job since that date? _____

If not, state the reason for the termination of your employment. _____
_____
_____

7. Have you missed any time from work as a result of your injury?_____

If so, give dates/hours you missed work because of injury.
_____
_____
_____
_____

8. Did you lose wages from the periods of time missed from work? _____
If so, state your total wage loss to date. _____

9. Have you received any increases or decreases in your pay since the accident? _____

If so, explain: _____
_____
_____
_____

10. If you have changed jobs since the accident give a summary of your present job, showing the name and address of your employer, rate of pay, hours, and type of work.

NAME AND ADDRESS	RATE OF PAY	HOURS WORKED	TYPE OF WORK

11. List your employment record as far back as you can remember. Your past employment record is important in determining your disability from an occupational viewpoint.

NAME AND ADDRESS OF EMPLOYER	EMPLOYED FROM __ TO __	REASON FOR LEAVING

12. What did you earn in the past year prior to your accident? _____

13. Have you filed income tax returns for the last three years? _____

    a. If so, where? _____

    b. Do you have copies of them? _____

    c. Will the figure shown in No. 12 above be the same as shown in your return? _____

EDUCATIONAL BACKGROUND

1. What education have you had, including any special employment training?

NAME OF SCHOOL	ADDRESS	HIGHEST GRADE COMPLETED

MEDICAL HISTORY

1. Prior Physical Examinations

List here EVERY physical examination you have ever had during the last TEN years, for employment promotion, insurance, selective service, armed forced, etc., stating the date, name of the doctor, and result, as fully as you can recall. Use extra sheets, if necessary.

Date: _____ Place:_____

Doctor's Name and Address: _____

_____

Purpose: _____ Result: _____

Date: _____ Place: _____

Doctor's Name and Address: _____
_____

Date: _____ Place:_____

Doctor's Name and Address: _____
_____

Purpose: _____ Result: _____

Date: _____ Place: _____

Doctor's Name and Address: _____
_____

2. Prior Accidents and Injuries

Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem. List here every such incident, whether it resulted in a claim for damages or not, stating the date, place, nature of the accident and extent of your injuries. If none, so state.

Date: _____ Place: _____

Nature of accident or injury: _____
_____
Extent of injury: _____
_____

Date: _____ Place: _____

Nature of accident or injury: _____
_____
Extent of injury: _____
_____
Date: _____ Place: _____

Nature of accident or injury: _____
_____
Extent of injury: _____
_____

Date: _____ Place: _____

Nature of accident or injury: _____
_____
Extent of injury: _____
_____
Date: _____ Place: _____

Nature of accident or injury: _____
_____
Extent of injury: _____
_____

3. Illnesses or Diseases

No matter how trivial an illness, either BEFORE or SINCE your accident, we must know about it. This is particularly true if there is any connection with your present physical complaints. The defendant will have available at the trial, by medical and hospital records, insurance records, etc., a complete history of your past physical condition.

Date: _____ Nature of illness/disease: _____

Duration: _____

Treated by: _____ Hospitalized _____

Date: _____ Nature of illness/disease: _____

Duration: _____

Treated by: _____ Hospitalized _____

Date: _____ Nature of illness/disease: _____

Duration: _____

Treated by: _____ Hospitalized _____

Have you ever had, or do you now, have trouble with your eye? _____

ears? _____ nose? _____ If so, explain _____

Have you ever worn glasses/contacts? _____ hearing aid? _____

If you currently wear glasses/contacts/hearing aid, who prescribed them, when?
_____
_____

Have you ever worn a brace, back or neck support? _____

If so, explain _____
_____

Have you ever been denied life or health insurance because of your health? _____

If so, by which company and why? _____
_____

4. Alcoholism & Mental and Nervous Disorders

If you have ever been treated for these afflictions, please be sure to discuss it with your attorney, confidentially, long before your case goes to trial.

THE INJURY

State all injuries known or believed by you to have been received as a result of this accident: _____
_____

Have you ever injured these areas of your body or received medical treatment to these areas of your body prior to this accident? _____

If yes, please be sure to include the relevant information in the Medical History portion of the questionnaire.

Disability - Length of time confined to bed: _____
and thereafter to house: _____

State present physical condition - scars, disabilities, deformities, discomforts, etc., due to the injuries received in this accident: _____
_____
_____

Activities eliminated or hampered as a result of this injury - List here all the usual activities which you have NOT been able to perform since the accident, such as cutting grass, dancing, etc., or activities you still do, but have DIFFICULTY doing.

_____

_____

Medical Treatment & Hospitalization

1. Hospitalizations related to this accident:

Name/Address: _____

Date Admitted: _____ Discharged: _____

Why admitted: _____

Nature of Treatment: _____

Name/Address: _____

Date Admitted: _____ Discharged: _____

Why admitted: _____

Nature of Treatment: _____

Name/Address: _____

Date Admitted: _____ Discharged: _____

Why admitted: _____

Nature of Treatment: _____

2. Physicians and Surgeons seen for injuries related to this accident:

Name: _____

Address: _____

Nature of treatment: _____

Still under care? _____

Name: _____

Address: _____

Nature of treatment: _____

Still under care? _____

Name: _____

Address: _____

Nature of treatment: _____

Still under care? _____

3. Nurses, Physical Therapists, Massage Therapists seen for injuries related to this accident:

Name: _____

Address: _____
Nature of treatment: _____

Still under care? _____

4. Witnesses. Our law firm believes that besides presenting medical evidence that describes your injuries, it is very important to have as witnesses various people who have noticed the effects of your injuries in your everyday life. Please list all of the people such as relatives, neighbors, co-workers, nurses, friends, etc., who may be able to compare your health before and after the accident.

NAME AND ADDRESS	TELEPHONE	RELATIONSHIP

4. Damages. Please list all the damages and expenses to date, OTHER THAN medical and prescription related expenses. Examples would be housekeeping, lawn care, transportation expenses, etc. Where possible, please include dates, addresses and enclose the bills.

DAMAGES	EXPENSES

SPECIAL DAMAGES

If you have received any bills for medical treatment related to the accident, list the charges below and enclose the bills.

		Total Charge	Present Charge
1.	Ambulance		
	_____	_____	_____
2.	Hospital		
	_____	_____	_____
	_____	_____	_____
3.	Doctors		
	_____	_____	_____
	_____	_____	_____
4.	Nurses and Therapists		
	_____	_____	_____
	_____	_____	_____
5.	Medical Appliances (Braces, crutches, walkers, etc.)		
	_____	_____	_____
	_____	_____	_____
6.	Drugs and Medicines		
	_____	_____	_____
	_____	_____	_____
7.	Miscellaneous Expenses		

_____ _____ _____

_____ _____ _____

THE ACCIDENT

Date of Accident: _____ Time: _____ a.m./p.m.

City: _____ County: _____

Weather Conditions: _____

Location of Accident (as to intersections or fixed objects)

_____

_____

In your own words, give a comprehensive account of the facts leading up to, during and following the accident:

_____

_____

_____

_____

How did you leave scene of accident? _____

Were pictures taken at the scene of the accident? _____ If yes, by whom, when and where? _____

Were you questioned by the police? _____

Were any tickets issued? _____ If yes, to whom? _____

Did you give or sign a statement? _____ If yes, for whom and when? _____

_____

Do you have a copy of the statement of statements? _____

Have you been questioned by an adjuster of investigator? _____ If yes, by whom, when and where? _____

_____

Was anyone else present at the time of the questioning? _____

Did you sign any papers? _____ Were you given a copy? _____

Had you consumed any alcohol or taken any medication/drugs on the day of the accident?
Yes _____ No _____

If yes, how much and/or what type? _____

Were you wearing a seat belt at the time of the accident? _____

Were you knocked unconscious as a result of the accident? _____

Estimated speed of vehicles: Yours: _____ Other driver: _____

Were there any skid marks at the scene? _____ Gouge marks? _____

Describe the vehicles involved _____

_____

Please list everything you believe caused or contributed to the cause of the accident:
_____

_____

_____

_____

PREMISES LIABILITY

To Whom the incident was reported: _____

Type of footwear inside or outside: _____

Exact location of incident: _____

WITNESSES

Provide us with a list of all the witnesses to the accident and their addresses and telephone number, if available, and any other people who may be of assistance in testifying about your case.

NAME AND ADDRESS	TELEPHONE

DIAGRAM OF ACCIDENT

Please draw a diagram of the scene of the accident as accurately as possible. Use the back of this sheet or an additional sheet of paper.

PAPERS AND DOCUMENTS

(Be sure to complete these requests carefully.)

A. PHOTOGRAPHS. If you have any, we would like to have any or all of the following photographs:

1. Scene of the accident.
2. Damage to the vehicles.
3. Pictures of your injuries - if someone else has taken photographs, (such as an insurance adjuster, friends, witnesses or news photographs) let us know immediately so that we can try to secure copies.

B. INSURANCE INFORMATION. Please send us:

1. Your automobile policy.
2. Homeowners liability policy.
3. Your Blue Cross or other hospitalization insurance policy and a copy of your insurance card.
4. Policies of any group insurance or special insurance such as disability insurance, accident insurance, etc.
5. Give us a list of all other insurance policies issued to any other members of your family or household. **This last item is very important**.

C. WAGE LOSS INFORMATION

1. Income tax returns for the past three (3) years.
2. Other evidence indicating income during the year preceding the accident.

D. MEDICAL EXPENSES

1. Medical bills.
2. Prescriptions receipts.
3. Ambulance bills.
4. Other expenses.

Date questionnaire completed: _____

Signature of person completing this form: _____

(If other than client, relationship to client: _____)