MULLINS LAW FIRM, P.A.

PERSONAL INJURY INTAKE FORM

Please answer each and every question so that we may better serve you. If a question does not apply to you, please indicate by inserting a "N/A" in response to the question. Thank you. If additional space is necessary to fully answer a question, please continue on the additional space provided.

Name: ____

Nature of Injury: ____

____

____

Date of Injury: ____________________ Were you treated by EMS? _____ Yes _____ No

Emergency Medical Care Provider: ____

Date of Initial Treatment for these injuries: ____________ Are you still under their care _____ Yes _____ No

Were you hospitalized as a result of this incident? _____ Yes _____ No

Date(s) of Hospitalization: ____

Name of Hospital(s): ____

Current Treating Physician(s): ____

____

Treatment received: ____

____

____

Regular Family Physician: ____

Pre-existing Illnesses, Injuries or Disabilities: ____

____

____

Medications due to Accident: ____

____

Prior Medications: ____

____

Are you currently undergoing physical therapy treatment? _____ Yes _____ No

If so, what treatment and under whose direction? ___________________________

____

____

Have you received a permanent impairment rating? _____ Yes _____ No

If so, what was the permanent impairment rating? ___________________________

Do you have Health Insurance: _______ If so, name of Company: ____________________

Has a claim been made against the policy: ________ Have you notified the Company of the injury? _______

Have you been contacted by an Insurance Adjuster? _____ Yes _____No When? ______________

Did you give a statement to Adjuster? _____ Yes _____No Was Statement Recorded? _____ Yes _____ No

At the time of injury, were you covered by MEDICARE or MEDICAID? _____ Yes _____ No

Have you received notice of any subrogation liens or reimbursement requests, whether verbal or in writing?

_____ Yes _____ No If so, from whom? __________________________________

Name of Responsible Party/ Defendant (if known): ____________________________

Brief description of incident: ____

____

____

____

____

Have photographs been taken of your injuries? _____ Yes _____ No

If so, when and by whom? ____

Have photographs been taken of the location of the incident? _____ Yes _____ No

If so, when and by whom? ____

Location of incident: ____

Were you under the influence of any drugs or alcohol at the time of the incident? _____ Yes _____ No

If so, how much: ____

Did Responsible Party/ Defendant admit liability? _____ Yes _____ No

If so, to who was the admission made? ____

Was the Responsible Party/ Defendant under the influence of any drugs or alcohol at the time of the incident? _____ Yes _____ No _____ Unknown

Was anyone else injured in this incident? _____ Yes _____ No

If so, whom: ____

Are you employed? ____ Yes ____ No Where? ____

Salary: ______________________________ Per: _____ Year _______ Hour ______ Week ______ Month

How many Hours per week were you working regularly prior to the incident? ____________________

Were you entitled to overtime pay if you worked overtime? _____ Yes _____ No

If yes, at what rate? ____

How long have you been employed at your current workplace? ____________________________

Immediate Prior Employer: ____

How long were you employed there? ____

Have you been absent from work as a result of the incident? _____ Yes _____ No

How much time have you missed as a result of this incident? ____________________________

Dates and amount of time absent due to Doctor Appointments/ Treatment: ____________________

____

Have you been absent from work due to injury prior to this incident? ______ Yes _____ No

When? ____

What is the total amount of wages you have lost due to this incident? ____________________

Did you receive any "sick leave" benefits from your employer? _____ Yes _____No

If so, the amount you received was: ____________________

Have you received any increases or decreases in pay since the incident? _____ Yes _____ No

Explain: ____________________

Have you filed income tax returns for the 3 years prior to the incident? ____ Yes ____ No

Are copies of the tax returns in your possession? _____ Yes _____ No

Will your claimed income listed above appear on those tax returns? _____ Yes _____ No

If not, please explain: ____________________

Have you ever filed a worker's compensation claim due to injury? _____ Yes _____ No

If so, when and for what injury? ____________________

____

Were you successful in recovering? _____ Yes _____No

Have you filed a worker's compensation claim for this injury? _____ Yes _____ No

<u>If so, please provide copies of these documents to MULLINS LAW FIRM, P.A.</u>

Have you ever been found disabled by worker's compensation board or social security administration?

_____ Yes _____ No

If so, when and by whom? ____________________

What is your highest level of education completed? ____________________

Aside from Medical expenses, have you incurred any other expenses in due to this injury? ____ Yes ____No

If so, please list inclusive of amounts: ____________________

____

____

____

Total amount of damages claimed due to this incident: ____________________

Closest Relative if we are unable to contact you: ______________________________

Address: ______________________________

Best Phone Number: (   ) ______________

Additional Responses:

Checklist of Plaintiff's Bodily Injuries

The information you provide here is confidential. This is a privileged attorney-client communication that will not be shared with anyone outside our office without your specific permission.

Check any and all items that were injured, and also any items that were involved, cut, bruised, or gave you any problems at any time after the injury.

1. HEAD

☐ Brain Injury ☐ Skull ☐ Forehead ☐ Eyes ☐ Ears ☐ Nose ☐ Face ☐ Teeth ☐ Mouth ☐ Lips ☐ Tongue ☐ Jaw ☐ Headaches ☐ Unconscious ☐ Seizures

2. NECK

☐ Throat ☐ Spine ☐ Muscles

3. UPPER EXTREMITIES

☐ Shoulders ☐ Arms ☐ Elbows ☐ Hands ☐ Wrists ☐ Fingers

4. CHEST

☐ Ribs ☐ Heart ☐ Lungs ☐ Other Internal Injuries

5. ABDOMEN

☐ Internal Injuries ☐ Hips ☐ Genital

6. BACK

☐ Thoracic (upper back) ☐ Lumbar (lower back) ☐ Sacrum ☐ Pelvis ☐ Shoulder blades

7. LOWER EXTREMITIES

☐ Thighs ☐ Legs ☐ Knees ☐ Ankles ☐ Feet ☐ Toes

8. GENERAL SYMPTOMS

☐ Headaches ☐ Dizziness ☐ Nausea ☐ Loss of normal skin function ☐ Pain ☐ Genital ☐ Urinary ☐ Sexual Problems ☐ Nervousness ☐ Fatigue ☐ Irritability ☐ Appetite ☐ Weight Loss ☐ Insomnia ☐ Change of Personality

Have you EVER had ANY pains or injuries before this accident in the same part of your body that gave you a problem after accident?

☐ Yes

☐ No

How do you describe your injuries? What got hurt? How did it affect you? If you cannot say enough to fill up the rest of this whole side of this sheet with your problems, you cannot expect a jury to take your problems seriously. **What were your problems because of the accident?**