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**CLIENT INITIAL INFORMATION
QUESTIONNAIRE PERSONAL
INJURY**

For Office Use Only

Atty/Paralegal _____

Date Opened _____

SOL _____

File No.: _____

GENERAL INFORMATION

The Attorney You are Seeing: _____ Date _____

Who referred you to Curry Law Group, P.A.? _____

Have you seen our advertisements in/on: ____TV ____Phone Book _____ which)
____Magazines ____Newspaper _____ which)

Are You a Prior Client? _____ If Yes, When? _____

Name of Attorney that Represented You _____

ABOUT YOU

Name: _____

Address: _____

City/State/Zip: _____

Phone: Home: _____; Work: _____

Cell/Pager: _____; Fax: _____

Email address: _____

DOB: _____; Social Security No.: _____

Driver's License No.: _____ State: _____

How long have you resided in Florida? _____

____Single ____Married ____Divorced ____Widowed

Spouse's Name: (If Applicable) _____

Spouse's Employer: _____ Work Phone: _____

Children(s) Name(s) & Age(s):

1. _____, Age ____ 2. _____, Age ____

3. _____, Age ____ 4. _____, Age ____

Clubs and Activities: _____

ABOUT THE ACCIDENT

Date of Accident: _____ Type of Accident: _____

Location of Accident: _____

Describe briefly about accident: _____

Please list year, make and model of vehicle you were driving at the time of this accident and list the damages sustained as a result of this accident:

Year: _____ Make: _____ Model: _____

Damages: _____

Do you have photographs of the damages taken of the vehicle? _____

Have the damages to the vehicle been repaired? _____ If yes, how much was the repair bill and do you have a copy of the repair bill? _____

Name of Law Enforcement Agency that investigated your accident: HCSO: _____

FHP: ____ TPD: ____ Other: _____ Agency Report No.: _____

Were you wearing your seatbelt/shoulder harness? _____ Did your airbags deploy? _____

Please list the name(s) and address(es) of any and all witnesses to this accident:

1 - Witness Name & Address/Phone No.

2 - Witness Name & Address/Phone No.

ABOUT YOUR EMPLOYER

Employer's Name: _____

Address: _____

City/State/Zip: _____ Occupation: _____

Have you lost time from work as a result of this accident? _____

If so, how long? _____

What is your average weekly salary? \$ _____/Gross No. of work hours: _____

ABOUT YOUR AUTOMOBILE INSURANCE (IF APPLICABLE)
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Insurance Company: _____

Policyholder Name (if other than yourself): _____

Ins. Co. Address: _____

Ins. Co. City/State/Zip: _____

Ins. Co. Telephone No.: _____

Claim Number/Adjuster: _____

Please list each and every vehicle in your household, including the owner and insurance company: _____

ABOUT THE ADVERSE PARTY

Name of Adverse Party: _____

Insurance Company: _____

Address: _____

City/State/Zip: _____

Telephone: _____

Claim Number/Adjuster: _____

ABOUT YOUR INJURIES

Describe your injuries from this accident: _____

Were you treated in the hospital? ____ If yes, name of hospital: _____

Were you transported to hospital by ambulance? _____

If yes, which EMS service transported you? _____

Are you being treated by a physician for your injuries sustained in this accident?

If so, please list every physician and medical facility that you have treated with below:

	Name of Physician/Clinic	Address/Phone Number
1)	_____	_____
2)	_____	_____

- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

(List additional physicians/Clinics on the back of this sheet)

Do You have any pre-existing injuries? _____ If so, please describe injuries and how injuries were sustained: _____

HEALTH INSURANCE

Name of Health Insurance: _____

Address: _____

Phone No.: _____

Policyholder Name: (If other than yourself) _____

Group No.: _____ Plan ID No.: _____

<FOR ATTORNEY USE ONLY

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