NEW CLIENT QUESTIONNAIRE

Instructions: Please complete the following New Client Questionnaire as completely as possible. Some sections may not apply to your specific case. Just complete the sections that are applicable to you and your case as thoroughly as you are able to.

Date: _____

Full Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Social Security Number: _____

Driver's License: _____

Nearest Relative/Alternative Contact Person: _____

Who referred you: _____

PERSONAL INFORMATION

Date of Birth: _____

Marital Status: _____

Date of Marriage: _____

Maiden Name: _____

Children:

Name(s)	Date(s) of Birth	Residing with?

Prior Convictions: _____

Any pending criminal/traffic matters: _____

Employment Status: _____

Name of Employer: _____

Job title/position: _____

Length of Employment: _____

Approximate annual gross income: _____

Name of spouse/partner/parent of child's employer: _____

Spouse/partner/parent of child's job position: _____

Length of spouse/partner/parent of child's employment:_____

Spouse/partner/parent of child's approximate annual gross income: _____

Military status: _____
Active Duty/Discharge Date and type: _____

Spouse/partner/parent of child's military status:_____
Active Duty/Discharge Date and type: _____

BUSINESS INFORMATION
Do you Own a Business: Y / N

Name of Business (Corp):_____

Name of D/B/A: _____

Address of Business: _____

Date of Incorporation: _____

Prior Business History (Citations/Violations/Suspensions/Revocation of Licenses): _____
_____

Any Debt Due City/County: Y / N
Amount: _____

Current/Pending Litigation involving Business: Y / N
Where: _____
Case No.: _____
Date Action Commenced: _____
Nature of Litigation: _____

PERSONAL INJURY INFORMATION
Date of Accident/Injury: _____

Location of Accident/Injury: _____

Accident/Injury reported: Y/ N
When: _____
To Whom: _____
Report Generated: Y / N
Copy of Report: Y / N

Emergency Personnel summoned: Y / N
Who: Fire / Police / Ambulance
What Municipality: _____
Statements Given: Y / N
To Whom: _____
When: _____

Photographs/Video Taken: Y/ N
Copy of photos/video: Y / N

Your Automobile Insurance:
Company: _____
Policy No.: _____
Effective Dates of Coverage: _____

Other Party Automobile Insurance:
Company: _____
Policy No.: _____
Effective Dates of Coverage: _____

Any communication with Insurance company(ies): Y / N
When: _____
Who: _____
What was communicated: _____

General summary of occurrence: _____
_____
_____

Any other witness(es) to occurrence: Y / N
Name(s): _____
Telephone No(s).: _____
Address(es): _____

Injury(ies)/Damages:

Describe Injury/Damage: _____

Drs./hospitals where you were seen: _____

_____

Amount of medical bills to date: _____

Did you lose time/wages from work due to injury: Y / N

Approximate Amount: _____

Any out of pocket expenses: Y / N

What Expenses: _____

How much: _____

Any other damages/expenses incurred: _____

Any Significant Medical History, if so specify: _____

_____