

PLAINTIFF'S AND PLAINTIFF'S FAMILY

1) Name(s): _____

2) Address: _____

3) Phone No. Home: _____ Cell: _____

Work: _____ E-Mail: _____

4) Have you ever been known by any other name? _____

5) Spouse: _____

6) Have you (or your spouse) ever filed a law suit against anyone before? _____

7) Have you ever had a law suit filed against you (or your spouse)? _____

8) Have you ever filed for annulment, separation, divorce or for the dissolution of current marriage? Yes _____ No _____ If yes, please give names and dates:

9) Do you currently receive any type of ssn disability, alimony or child support? If so how much and how often? _____

10) Please list the names, ages and with whom your children live: _____

11) Have you ever filed workers compensations? Yes _____ No _____

12) Current Employer name, supervisor name, address and phone number: _____

13) Job Title: _____ Average hours per week: _____

14) Rate of pay: _____ Overtime: Yes _____ No _____

15) How long have you been with the company? _____

16) Were you a member of a Union? _____

17) Health Insurance ID: _____ Phone Number: _____

*****Please provide copies of your w-2, pay stubs and health ID card.*****

18) Automobile Insurance Carrier: _____
Address and Phone No. and Policy No. _____

*****Please provide a copy of your declarations page.*****

Physical and Mental Health and History

A. Please describe all illnesses and/ or injuries you experienced in the past 10 years. For each please include dates, nature/cause, and length of time out of work and name and number of any treating physicians: _____

B. Please describe the impact that any of the above illnesses or injuries may have on your ability to perform normal activities or to shorten your normal life expectancy? _____

C. Please list name, address and phone number of primary physician: _____

D. Prior to the injury, have you ever complained of or exhibited serious physical problems? Yes _____ No _____ If so, please describe in detail: (Omit previous given information) _____

E. Are you Diabetic? Yes _____ No _____, If yes, type I _____ type II _____
F. Do you smoke? Yes _____ No _____, If yes, how much per day? _____
G. Do you drink? Yes _____ No _____, If yes, how often? _____

- H. Do you wear glasses or contacts? Yes _____ No _____, If yes, nearsighted or farsighted? _____
- I. Are you color blind? Yes _____ No _____
- J. Have you ever received a disability rating or pension? Yes _____ No _____
- K. Have you ever received a medical discharge from military service?
Yes _____ No _____
- L. Have you ever been terminated, relieved of duty or placed on light duty because of physical limitations? Yes _____ No _____, If yes, when? _____
- M. Have you, in the last 10 years, been diagnosed with any sort of mental illness?
Yes _____ No _____, If yes, what were you diagnosed with and when? _____

- N. Please describe the impact that any of the above illnesses may have on your ability to perform normal activities or to shorten your normal life expectancy?

- O. Please list name, address and phone number of primary physician: _____

- P. Have you ever been institutionalized? Yes _____ No _____, If yes, when and where? _____

*****PERSONAL INFORMATION*****

- 1) Have you ever served in the armed forces of the United States or any other country? Yes _____ No _____ If yes, please state branch of service, rank achieved, dates of service, and whether you had received an honorable discharge:

- 2) Do you possess a driver's license? Yes _____ No _____
- 3) Have you ever been convicted of any crime? Yes _____ No _____ If yes, explain:

- 4) Please describe what you feel you have lost as a result of your injury? _____

5) Have you ever held any public office or position? Yes _____ No _____ If so, state when, what office, how the position was attained and the name, address and phone number of someone who would be familiar with your performance: _____

6) Do/ did you help around the home? Yes _____ No _____ If yes, list chores:

7) Please list all medically related expenses: _____

8) Was any of your money, jewelry or other possessions lost or destroyed in the accident? Yes _____ No _____ If yes, please list each item and give approximate value: _____

9) Do you claim any other expense as a result of the injury? Yes _____ No _____ If yes, please itemize: _____

10) Has your standard of living changed as a result of your injury? Yes _____ No _____ If yes, please describe: _____

11) Please add any other information you feel would be helpful to show your loss:

***** Please provide copies of drivers license and any receipts.*****

12) Please list each person who would be a good witness as to your business/ occupational abilities, community/religious and/or cultural life activities, family relationships and personal traits/ character:

Name: _____
Address: _____
Age: _____
Knowledge of you: _____

Name: _____
Address: _____
Age: _____
Knowledge of you: _____

Name: _____
Address: _____
Age: _____
Knowledge of you: _____

***** Automobile/Motorcycle Accidents*****

- 1) Were you the driver, passenger or pedestrian? _____
- 2) If you were the driver, do you own the vehicle? _____
- 3) What are your policy limits? (Please provide declaration page if possible)
- 4) Did you file a claim? Yes ___ No ___ With who? _____
- 5) Was a police report filed? Yes ___ No ___ Where? _____
- 6) Were there any witnesses? Yes _____ No _____
- 7) Were you taken to the hospital by an ambulance? Yes _____ No _____
- 8) Were you treated in an emergency room? Yes _____ No _____
- 9) What hospital were you taken to? _____
- 10) Were you employed at the time of the accident? Yes _____ No _____
- 11) Have you been in an automobile accident before? Yes _____ No _____
- 12) When and what happened? _____

13) What were your injuries? _____

