PERSONAL INJURY QUESTIONNAIRE

DATE OF LOSS: _____ TYPE OF CLAIM: _____

PLAINTIFF

NAME:_____

ADDRESS: _____

DOB: _____ SSN: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

EMPLOYMENT

EMPLOYER: _____

NATURE OF WORK/JOB TITLE: _____

ADDRESS: _____

HOURS/DAYS PER WEEK: _____ WAGE/SALARY: _____

TIME LOST: _____

PREVIOUS INJURIES OR CLAIMS: _____

INSURANCE CARRIER: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

ADJUSTER: _____

NAMED INSURED: _____

DEFENDANT

NAME:_____

ADDRESS: _____

INSURANCE CARRIER: _____

POLICY NUMBER: _____

CLAIM NUMBER: _____

ADJUSTER: _____

NAMED INSURED: _____

INCIDENT

DATE: _____ TIME: _____

LOCATION: _____

DESCRIPTION OF INCIDENT (WHAT HAPPENED?): _____

_____

WHICH POLICE STATION RESPONDED? _____

TRAFFIC COURT: _____ DATE/TIME: _____

INCIDENT REPORT NUMBER: _____

INJURIES

NATURE OF INJURIES: _____

WERE YOU TRANSPORTED BY AMBULANCE? IF YES, WHICH ONE? _____

MEDICAL TREATMENT FACILITIES: Name/Address/Date of Service

1. _____
2. _____
3. _____

PHYSICAL RESTRICTIONS AND/OR LIMITATIONS: _____

_____

_____