



SAM LAW, LLC

Making a difference every day

INITIAL CLIENT INTERVIEW

Date: _____ Referral Source: _____

Atty: _____ Legal Asst.: _____

Office: _____

BACKGROUND INFORMATION

Full Name: _____
First Middle Last

Other names known by: _____

Address: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____

Mobile: _____

Date of birth: _____ Social Security #: _____

Driver's license number: _____

Marital status: _____

Spouse's name: _____

OCCUPATION

Employer: _____

Address: _____

Job Title: _____ How long employed? _____

Name of Supervisor: _____ Telephone: _____

Your last date worked before illness or injury: _____

Rate of Pay: _____ - Per: Month- Week- Bimonthly

Date returned to work: _____

INCIDENT INFORMATION

Type of injury: automobile slip and fall dog bite medical negligence other: _____

Date of Injury: _____ Time: _____ SOL: _____

Location: _____ County: _____

Weather Conditions: _____

If Automobile accident: Status: driver passenger pedestrian other (circle one).

If passenger who was driver?

Were police called? _____ Agency: _____

Was fire department called? _____ Agency: _____

Was ambulance called? _____ Agency: _____

List any citations given and to whom: _____

Describe what happened: _____

Draw a diagram of the accident scene:

AUTOMOBILE ACCIDENT INSURANCE INFORMATION

Vehicle (Year/make/model): _____

Plate number: _____

Describe damage to your vehicle: _____

Location of your vehicle: _____

Property damage resolved: _____

Were photos taken? _____ Location of photos: _____

1. Vehicle in which you were driver/passenger at time of accident

Auto insurance company: _____

Address: _____

Policyholder/insured if not you: _____

Policy Number: _____ Claim number: _____

Adjuster Name: _____ Phone #: _____

Policy limits: _____

2. Your vehicle (if different) or vehicle on which you are named insured or household member

Auto insurance company: _____
Address: _____
Policyholder/insured if not you: _____
Policy Number: _____ Claim number: _____
Adjuster Name: _____ Phone #: _____
Policy limits: _____

INJURY ON PREMISES

1. Were you on the job at the time of the accident: Yes No

Workers' compensation insurance company: _____
Address: _____
Insured: _____ Claim Number: _____
Adjuster: _____ Phone number: _____

2. If not on job, Where did the accident take place:

Did you slip and fall? _____
What happened? _____

3. Your health insurance company: _____
Address: _____
Policyholder: _____ ID number: _____
Group number: _____

4. Is this a medical negligence case? Yes No

Body part affected: _____

Describe your injury: _____

Is injury permanent? Yes No

Did death or disability result? Yes No If yes, please describe: _____

Other Party Information

Other party #1

Name: _____
Address: _____

City, State, Zip: _____
Auto accident only: Driver's license No.: _____
Vehicle: _____ Plate No. _____
Auto insurance company: _____
Address: _____
Policyholder/insured if not you: _____
Policy Number: _____ Claim number: _____
Adjuster Name: _____ Phone #: _____
Policy limits: _____

Other party #2

Name: _____
Address: _____
City, State, Zip: _____
Auto accident only: Driver's license No.: _____
Vehicle: _____ Plate No. _____
Auto insurance company: _____
Address: _____
Policyholder/insured if not you: _____
Policy Number: _____ Claim number: _____
Adjuster Name: _____ Phone #: _____
Policy limits: _____

For additional defendants, use the back of this form

WITNESS INFORMATION

Names of any witnesses: (please include addresses and telephone numbers, if known.)

Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INJURIES/MEDICAL TREATMENT

List all **INJURIES** that you received as a result of this accident.

List the names of every **HOSPITAL** you have been seen at since the accident occurred whether or not you were treated for injuries caused by the accident. Include dates and reasons for each hospitalization.

Date of Admission	Hospital	Reason
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List the names and addresses of all **DOCTORS** who have treated you for your injuries.

List the names and addresses of all **PHYSICAL THERAPISTS** who have treated you for your injuries.

Describe every past injury, accident, including work-related accidents, in which you have ever been involved. (Include date, time, location, type of accident, and injuries.)

List all illnesses or injuries for which you were being treated at the time of the accident.

ADDITIONAL BACKGROUND INFORMATION

List every claim or lawsuit in which you have been involved in any way. Include approximate year, parties involved, reasons and results.

Have you ever been arrested? _____
If yes, please provide the following information:

Date: _____ Charge: _____

Have you ever been convicted of a crime? Yes No

If yes, please provide the following information:

Date: _____ Charge: _____

Date: _____ Charge: _____

Result (fine, penalty, supervision, etc.) _____

Have you ever filed for bankruptcy: Yes No

If yes, please provide the following information: CH 7 or CH13 (circle one)

Date of filing: _____ Date of Discharge: _____

Attorney Name: _____ Telephone: _____

Have you ever been represented by another attorney? Yes No

Attorney Name: _____ Telephone: _____

Address: _____ Reason: _____

Give any other information you feel we should have to represent you effectively in this case:
