Medical Malpractice

INJURY INTAKE FORM

It is important that you complete this form as accurately and completely as possible.

Name: _____

Date of Birth: _____

Social Security Number: _____

Address:

_____

_____

_____

_____

Length of Time at that Address: _____ years _____ months

Home Telephone Number: _____

Work Telephone Number: _____

Cell Phone: _____

Facsimile Number: _____

E-mail Address: _____

Former/ Maiden Name(s): _____

Date of injury:_____

Describe what malpractice you believe occurred:

_____

_____

_____

_____

Describe all injuries sustained:

_____

_____

_____

_____

List all physicians, hospitals, or others you believe may be responsible for your injuries:

_____

_____

_____

_____

Your health insurance(s) (name and phone number):

_____

_____

_____

_____

List all doctors, hospitals, physical therapists, chiropractors, or others who have treated you for this injury:

Name: _____

Tel. Number: _____

Address: _____

Name: _____

Tel. Number: _____

Address: _____

Name: _____

Tel. Number: _____

Address: _____

Name: _____

Tel. Number: _____

Address: _____

Have you ever suffered injuries or had illnesses similar to those suffered in this incident?_____

Date/ Description.

_____

_____

_____

_____

Employment Information:

Current Employer: _____

Job Position/Title: _____

Employer's Address/phone number:

_____

_____

_____

Length of Time with Employer: _____ years

Gross Monthly Income: $_____

Have you lost wages due to your injury?_____

How many days/ months? _____

Do you expect to lose additional income in the future? _____

Marital Status: _____

Current Prescription Medications Being Taken, Including Current Dosage and Name of Prescribing Physician or

Medical Provider:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Current Over-the-Counter Medicines Being Taken

_____

_____

_____

_____

_____

_____

Previous Prescription Medications Taken, Including Dosage and Name of Prescribing Physician:

_____

_____

_____

_____

_____

_____

Do your injuries prohibit performance of any daily living activities? (Examples: Can you brush your hair?

Perform household tasks such as cleaning and cooking?) If so, for how long have you been unable to perform

these activities?:

_____

_____

_____

_____

_____

_____

Hobbies/Interests:

_____

_____

_____

Does illness prevent you from engaging in these hobbies/interests?_____

Do you have a history of treatment for chemical dependency? _____

Do you have a history of psychiatric or psychological treatment? _____

Explain:

_____

_____

_____

_____

Do you have a criminal record? _____

Explain:

_____

_____

_____

_____

Have you ever made any previous claims for personal injuries, medical malpractice, workers' compensation, or

social security disability? If yes, please explain:

_____

_____

_____

_____

General instructions:

1. Take photographs of your injuries, if possible.

2. Give no information to anyone other than our office.

3. Forward copies of all bills or receipts for hospital, x-ray, loss of earnings and medical reports.

4. Additional instructions will be given to you based on your individual situation.

Client Verification:

Date: _____ Signature: _____

***COMPLETING THIS FORM DOES NOT CREATE AN ATTORNEY/CLIENT RELATIONSHIP. THIS FORM IS FOR INFORMATIONAL PURPOSES ONLY. ***