

## CLIENT INFORMATION SHEET

*The information you give us on this form is very important. It will help us investigate your accident and determine how to best proceed with your case. If you don't have all the information we ask for in this form, please let us know so we can help you get it. All of your answers will be kept strictly confidential.*

Today's date: \_\_\_\_\_

How were you referred to **The Law Offices of Dianne L. Sawaya, LLC?**

\_\_\_\_\_

### PERSONAL INFORMATION

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

Telephone no.: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you: Right-handed \_\_\_\_\_ Left-handed: \_\_\_\_\_

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's phone no.: \_\_\_\_\_

Dependents and ages: \_\_\_\_\_

\_\_\_\_\_

Your driver's license: No. \_\_\_\_\_ Exp. date: \_\_\_\_\_

### \*\*\*\*IMPORTANT INFORMATION\*\*\*\*

Please list the name of a relative or friend who does not live with you: (for contact in an emergency and we can't reach you)

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

**INFORMATION ON THE ACCIDENT**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

What was the weather like (sunny, raining, snowing, etc.)? \_\_\_\_\_

What were the road conditions like? \_\_\_\_\_

Please answer these questions about the vehicle YOU were in:

Vehicle make and model: \_\_\_\_\_

License plate no.: \_\_\_\_\_ Who owns the vehicle? \_\_\_\_\_

Were you driving the car/truck? Yes \_\_\_ No \_\_\_

If a passenger, in which seat were you sitting? \_\_\_\_\_

Where was the damage to your car/truck?                      Front \_\_\_ Rear \_\_\_  
Right side \_\_\_ Left side \_\_\_

Were any windows broken? Yes \_\_\_ No \_\_\_

Did any seats break or come loose in the accident? Yes \_\_\_ No \_\_\_

Was the vehicle drivable? Yes \_\_\_ No \_\_\_

Were you wearing a seat belt? Yes \_\_\_ No \_\_\_

Please answer these questions about the OTHER vehicle:

Vehicle make and model: \_\_\_\_\_

License plate no.: \_\_\_\_\_ Who owns the vehicle? \_\_\_\_\_

Was the other vehicle a:  
\_\_\_ Government vehicle, such as a bus  
\_\_\_ Corporate vehicle, such as a delivery truck  
\_\_\_ Construction equipment, such as a dump truck

Where was the damage to the other car/truck?                      Front \_\_\_ Rear \_\_\_  
Right side \_\_\_ Left side \_\_\_

Were any windows broken? Yes \_\_\_ No \_\_\_

Was the vehicle drivable? Yes \_\_\_ No \_\_\_

Did anyone take photographs at the accident scene? Yes \_\_\_ No \_\_\_

Their name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Were any vehicles towed from the accident scene? Yes \_\_\_ No \_\_\_

Whose vehicle was towed? \_\_\_ Yours \_\_\_ Other driver's

What is the name of the towing company? \_\_\_\_\_

Where was your vehicle towed? \_\_\_\_\_

Were damage estimates prepared on the vehicle you were in? Yes \_\_\_ No \_\_\_

By whom? \_\_\_\_\_ Amount of estimated damage? \_\_\_\_\_

Has the vehicle been repaired? Yes \_\_\_ No \_\_\_ Who repaired it? \_\_\_\_\_

Please briefly describe the accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did an ambulance come to the scene? Yes \_\_\_ No \_\_\_ Ambulance  
Name: \_\_\_\_\_

Were you transported to the hospital? Yes \_\_\_ No \_\_\_ Hospital Name: \_\_\_\_\_

Were there other people in the car? Yes \_\_\_ No \_\_\_

Were they injured? Yes \_\_\_ No \_\_\_

Were any of them transported to the hospital? Yes \_\_\_ No \_\_\_

Were police notified? Yes \_\_\_ No \_\_\_ Did the police investigate the accident? Yes \_\_\_ No \_\_\_

Which police department/city? \_\_\_\_\_

Did the police issue you a ticket/summons? Yes \_\_\_ No \_\_\_

Did the police issue the other driver a ticket/summons? Yes \_\_\_ No \_\_\_

In your opinion, was the other driver under the influence of alcohol or drugs? Yes \_\_\_ No \_\_\_

Did you make any statements to anyone at the scene? Yes \_\_\_ No \_\_\_

To whom: \_\_\_\_\_

What did you say? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did anyone make any statements to you at the scene? Yes \_\_\_ No \_\_\_

Who made the statements? \_\_\_\_\_

What did they say? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any past motor vehicle accidents you've been in, any Worker's Compensation claims you have filed, or claims of any other sort you've made:

\_\_\_\_\_  
\_\_\_\_\_

**INFORMATION ON THE OTHER DRIVER**

Name: \_\_\_\_\_ Vehicle owner: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

Telephone no.: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Their driver's license: No. \_\_\_\_\_ Exp. date: \_\_\_\_\_

If the other vehicle was a company vehicle:

Company's name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

Telephone no.: \_\_\_\_\_

**INFORMATION ON WITNESSES**

Were there any witnesses to the accident? Yes \_\_\_ No \_\_\_

*Please list witnesses, including all people inside the car you were in and where they were sitting, and anyone who witnessed the accident from outside the car. In a brief sentence tell what they would be able to say for you and how they could explain how your injuries have affected you.*

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Name: \_\_\_\_\_ Phone no.: \_\_\_\_\_

**INSURANCE INFORMATION**

If YOU were driving:

Is your car insured? Yes \_\_\_ No \_\_\_

Name of your insurance company: \_\_\_\_\_

Name of your agent or adjuster? \_\_\_\_\_

Phone no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Have you notified your insurance company? Yes \_\_\_ No \_\_\_

What is the claim number they assigned to this case? \_\_\_\_\_

Policy limits on your insurance:

Property damage:

\$25,000/\$50,000 \_\_\_

\$50,000/\$100,000 \_\_\_

\$100,000/\$300,000 \_\_\_

Uninsured motorist:

\$25,000/\$50,000 \_\_\_

\$50,000/\$100,000 \_\_\_

\$100,000/\$300,000 \_\_\_

\$250,000/\$500,000 \_\_\_

Does your policy have medical payments coverage? Yes \_\_\_ No \_\_\_

Amount of medical payments coverage:

\$1,000 \_\_\_

\$5,000 \_\_\_

\$10,000 \_\_\_

\$15,000 \_\_\_

\$20,000     \_\_\_  
\$25,000     \_\_\_

If you were a PASSENGER:

Is the driver's car insured? Yes \_\_\_ No \_\_\_

Name of driver's insurance company:

\_\_\_\_\_  
\_\_\_\_\_

Name of driver's agent or adjuster? \_\_\_\_\_

Phone no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Has the driver notified his insurance company? Yes \_\_\_ No \_\_\_

What is the claim number they assigned to this case? \_\_\_\_\_

Policy limits on driver's insurance:

Property damage:

\$25,000/\$50,000     \_\_\_

\$50,000/\$100,000   \_\_\_

\$100,000/\$300,000  \_\_\_

Uninsured motorist:

\$25,000/\$50,000     \_\_\_

\$50,000/\$100,000   \_\_\_

\$100,000/\$300,000  \_\_\_

\$250,000/\$500,000  \_\_\_

For the OTHER DRIVER:

Is the driver's car insured? Yes \_\_\_ No \_\_\_

Name of his insurance company: \_\_\_\_\_

Name of his agent or adjuster? \_\_\_\_\_

Phone no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Have they notified their insurance company? Yes \_\_\_ No \_\_\_

What is the claim number they assigned to this case? \_\_\_\_\_

Policy limits on other driver':

Property damage:

\$25,000/\$50,000     \_\_\_

\$50,000/\$100,000   \_\_\_

\$100,000/\$300,000  \_\_\_

Liability coverage:

\$25,000/\$50,000 \_\_\_  
\$50,000/\$100,000 \_\_\_  
\$100,000/\$300,000 \_\_\_  
\$250,000/\$500,000 \_\_\_

Have you been contacted by his insurance company? Yes \_\_\_ No \_\_\_

Have you received any letters from any other insurance company asking question about this accident? Yes \_\_\_ No \_\_\_

Has anyone taken your recorded statement? Yes \_\_\_ No \_\_\_

If so, who took it? \_\_\_\_\_ When? \_\_\_\_\_

Do you have health insurance? Yes \_\_\_ No \_\_\_

Name of plan: \_\_\_\_\_

Insurer contact: \_\_\_\_\_ Phone no.: \_\_\_\_\_

Group/policy no.: \_\_\_\_\_ Member no.: \_\_\_\_\_

Does Medicare or Medicaid pay any of your medical bills? Yes \_\_\_ No \_\_\_

If yes, what is your Medicare/Medicaid no.:

\_\_\_\_\_

Do you receive Social Security? Yes \_\_\_ No \_\_\_ If yes: SSD \_\_\_ SSI \_\_\_

### **INFORMATION ABOUT YOUR WORK**

Were you on the job at the time of the accident? Yes \_\_\_ No \_\_\_

Employer's name: \_\_\_\_\_

Employer's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Income at the time of the accident: \$ \_\_\_\_\_ per \_\_\_\_\_

Any other income (commissions, bonuses, second job etc.): \$ \_\_\_\_\_

Income now: \$ \_\_\_\_\_ per \_\_\_\_\_

Any other income (commissions, bonuses, second job etc.): \$ \_\_\_\_\_

Has this accident affected your ability to do your job? Yes \_\_\_ No \_\_\_

As a result of this accident, have you missed any time from work? Yes \_\_\_ No \_\_\_

Are you working now? Yes \_\_\_ No \_\_\_

Are you receiving worker's compensation insurance? Yes \_\_\_ No \_\_\_

Are you receiving disability insurance? Yes \_\_\_ No \_\_\_

For how many days so far: \_\_\_\_\_

Name of the doctor who told you not to work: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP : \_\_\_\_\_

**INFORMATION ABOUT YOUR INJURIES**

Please list any medical complaints or symptoms you think may have been caused by the accident:

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Please describe any bruises, cuts or other visible injuries that were caused by the accident (for example, bruises or cuts from the seat belt):

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Did you hit your head on anything in the accident? Yes \_\_\_ No \_\_\_

Please describe: \_\_\_\_\_

Did you lose consciousness? Yes \_\_\_ No \_\_\_ For how long? \_\_\_\_\_

If you don't think you lost consciousness, is there anything about the accident you don't recall (such as time of the accident, taking off your seat belt)? Yes \_\_\_ No \_\_\_

If yes, please describe:

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Please list the names of all medical facilities you've been to since the time of the accident.

<b>FACILITIES</b>	<b>FULL NAME</b>	<b>PHONE NUMBER/ADDRESS</b>
Emergency department:		
Hospital		
Imaging center (X-rays, MRI etc.)		
Walk-in clinic:		
Doctor:		
Chiropractor:		
Physical therapist:		
Other:		

Have your eyes hurt since the time of the accident? Yes \_\_\_ No \_\_\_

Have your ears hurt, seemed stuffy or had ringing in them? Yes \_\_\_ No \_\_\_

Have you had dizzy spells or a feeling the room is spinning? Yes \_\_\_ No \_\_\_

Have you had pain or stiffness in your jaw since the accident? Yes \_\_\_ No \_\_\_

Have you noticed a "click" or catch in your jaw since the accident? Yes \_\_\_ No \_\_\_

Have you had headaches as a result of the accident? Yes \_\_\_ No \_\_\_

Please describe the headaches (dull or sharp, location, how often, how long):

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How often do you get these headaches? \_\_\_\_\_

How long do these headaches last? \_\_\_\_\_

Does your back hurt as a result of the accident? Yes \_\_\_ No \_\_\_

What part of your back? \_\_\_\_\_

How often does your back hurt? \_\_\_\_\_

Does your neck hurt as a result of the accident? Yes \_\_\_ No \_\_\_

Have you noticed a "clunk" or grinding sound in your neck? Yes \_\_\_ No \_\_\_

How often does your neck hurt? \_\_\_\_\_

Have you had any pain in your arms or legs since the accident? Yes \_\_\_ No \_\_\_

Where is the pain? \_\_\_\_\_

Have your arms or legs been numb since the accident? Yes \_\_\_ No \_\_\_

Where? \_\_\_\_\_

Since the accident, have you had problems with any of the following?

- |  |                |
|--|----------------|
| Loss of sense of smell                   | Yes ___ No ___ |
| Change in your sense of smell            | Yes ___ No ___ |
| Changes in vision                        | Yes ___ No ___ |
| Changes in hearing                       | Yes ___ No ___ |
| Muscle weakness                          | Yes ___ No ___ |
| Trouble walking                          | Yes ___ No ___ |
| Problems dropping things                 | Yes ___ No ___ |
| "Pins and needles" sensations            | Yes ___ No ___ |
| Coordination problems                    | Yes ___ No ___ |
| Balance problems                         | Yes ___ No ___ |
| Tremors or shakiness                     | Yes ___ No ___ |
| Dizziness                                | Yes ___ No ___ |
| Vomiting                                 | Yes ___ No ___ |
| Blackout spells                          | Yes ___ No ___ |
| Fainting spells                          | Yes ___ No ___ |
| Seizures or fits                         | Yes ___ No ___ |
| Periods where you lose time              | Yes ___ No ___ |
| Feelings of being in a daze              | Yes ___ No ___ |
| Hallucinations                           | Yes ___ No ___ |
| Illusions:                               | Yes ___ No ___ |
| Changes in appetite, either more or less | Yes ___ No ___ |

Have you ever had or been diagnosed as having any of the following?

- |                        |                |
|------------------------|----------------|
| Serious infections     | Yes ___ No ___ |
| Diabetes               | Yes ___ No ___ |
| Liver problems         | Yes ___ No ___ |
| Kidney problems        | Yes ___ No ___ |
| Problems with arteries | Yes ___ No ___ |
| Stroke                 | Yes ___ No ___ |

High blood pressure	Yes ___ No ___
Heart problems	Yes ___ No ___
Blood problems	Yes ___ No ___
Cancer	Yes ___ No ___

Please list any surgeries you have had before the accident.

Date	Surgery	Doctor	Hospital
_____	_____	_____	_____
_____	_____	_____	_____

**OTHER AREAS AFFECTED BY THE ACCIDENT**

Since the accident, have you continued to do activities around the house, even though they're more difficult or cause you pain? Yes \_\_\_ No \_\_\_

Since the accident, have you stopped doing things you used to enjoy (such as sports, gardening, travel) because they're more difficult or cause you pain? Yes \_\_\_ No \_\_\_

What are you not able to do anymore because of the accident? \_\_\_\_\_

Since the accident, have you had problems with any of the following?

Flashbacks to the accident?	Yes ___ No ___
Nightmares?	Yes ___ No ___
Intrusive thoughts?	Yes ___ No ___
Fear or uneasiness about driving?	Yes ___ No ___

Since the accident, has your sex drive changed? Yes \_\_\_ No \_\_\_

If so, is it: More \_\_\_ Less \_\_\_

Since the accident, have you had problems with:

Stress, tension or tense muscles	Yes ___ No ___
Anger or keeping your temper	Yes ___ No ___
Controlling your actions	Yes ___ No ___

Since the accident, do you have:

Physical fatigue	Yes ___ No ___
Sleep disturbances	Yes ___ No ___
Trouble falling asleep or staying asleep	Yes ___ No ___
Trouble waking up too early	Yes ___ No ___
Tendency to sleep at abnormal times	Yes ___ No ___

Do you drink alcohol? Yes \_\_\_ No \_\_\_

How many drinks per day? \_\_\_\_\_

Is this more or less than before the accident? More \_\_\_ Less \_\_\_ Same \_\_\_\_\_

Do you use drugs recreationally Yes \_\_\_ No \_\_\_

What drugs do you use? \_\_\_\_\_

Is this more or less than before the accident? More \_\_\_ Less \_\_\_ Same \_\_\_\_\_

Have you ever been addicted to any drugs? Yes \_\_\_ No \_\_\_

What drugs? \_\_\_\_\_

Since the accident, have you had trouble with any of the following?

Using tools	Yes ___ No ___
Telling right from left	Yes ___ No ___
Getting dressed	Yes ___ No ___
Remembering things	Yes ___ No ___
Understanding others	Yes ___ No ___
Following a conversation	Yes ___ No ___
Speech	Yes ___ No ___
Reading	Yes ___ No ___
Writing	Yes ___ No ___

Since the accident, do you:

Get lost often	Yes ___ No ___
Forget where you are	Yes ___ No ___
Forget the time and day	Yes ___ No ___
Forget meetings and appointments	Yes ___ No ___

Since the accident, does it seem that you:

Can't think as quickly anymore	Yes ___ No ___
Find it hard to think clearly	Yes ___ No ___
Are more easily distracted	Yes ___ No ___
Have trouble with "common sense"	Yes ___ No ___
Become confused easily	Yes ___ No ___
Can't plan activities as well as before	Yes ___ No ___
Can't learn new things	Yes ___ No ___
Have difficulty with new situations	Yes ___ No ___

Since the accident, do you:

Hear unusual sounds	Yes ___ No ___
See unusual things	Yes ___ No ___
Have strange feelings	Yes ___ No ___
Have bizarre thoughts	Yes ___ No ___
Think about suicide	Yes ___ No ___

Tried to commit suicide                    Yes \_\_\_ No \_\_\_  
Plan to commit suicide                    Yes \_\_\_ No \_\_\_  
Have new phobias                            Yes \_\_\_ No \_\_\_

Since the accident, have you felt:

Depressed or down in the dumps        Yes \_\_\_ No \_\_\_  
Anxious or had panic attacks            Yes \_\_\_ No \_\_\_  
Preoccupied with yourself                Yes \_\_\_ No \_\_\_  
Impulsive                                    Yes \_\_\_ No \_\_\_  
A need for immediate gratification      Yes \_\_\_ No \_\_\_  
Alienated from others                    Yes \_\_\_ No \_\_\_  
Anti-social                                Yes \_\_\_ No \_\_\_  
Uncooperative                              Yes \_\_\_ No \_\_\_  
Apathetic or withdrawn from others    Yes \_\_\_ No \_\_\_  
Obsessed about things:                    Yes \_\_\_ No \_\_\_

Have you suffered a head injury in the past?    Yes \_\_\_ No \_\_\_

If yes, please describe when and how it happened:

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Is there anything else you can think of that we should know?

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*Thank you for taking your time to fill out this form. Even though it was time-consuming, it provides us with valuable information that we need to properly take care of your case. Please be assured that we will keep this information strictly confidential and will not release it to anyone outside The Law Offices of Dianne L. Sawaya, unless you tell us to or give us permission to as part of your case, or as may be required by law.*