CARLSON, MEISSNER HART & HAYSLETT, P.A.

The Law Offices of Carlson & Meissner

CLIENT INFORMATION SLIP AND FALL ACCIDENT

Date: _____

Attorney: _____

I. Referral Information

How were you referred to our office?

Doctor _____ Attorney _____

Client _____ Other _____

TV ___(Brighthouse) ___(Verizon Fios)

Yellow Pages (circle correct ad):	Hernando County -	attorney ad	criminal	W/C
	New Port Richey -	attorney ad	criminal	W/C
	Tarpon Springs -	attorney ad		
	Clearwater -	attorney ad		W/C
	St. Petersburg -	attorney ad	criminal	

II. Client Personal Information

First, Middle, Last Name: _____

Address: _____

Street *City* *State* *Zip*

Telephone: Home_____ Work_____ Cell _____

Email Address: _____

I am granting permission for the law firm to forward confidential information to me regarding my case via Email. Yes/No

Social Security Number:_____ Sex: _____ Race: _____

Date of Birth: _____ Age: _____ Is injured party a minor? Yes/No

If minor, name of parent/guardian:_____

Are you literate in English? Yes/No Are you a high school graduate? Yes/No

If you are not a high school graduate, GED? Yes/No Years of college completed:_____

Are you currently represented by an attorney for any other matter? Yes/ No If yes, please give the name of the attorney and describe the matter for which you are represented.

_____
_____
_____

Have you ever been involved in a lawsuit? Yes/ No If yes, please explain the nature, date, county and state of the lawsuit:_____
_____
_____

Married: Yes/No If yes, spouse's name: _____

Children (Names/Ages): _____
_____

Have you served in the military? Yes/No If yes, in what branch did you serve?_____

Have you ever been convicted of a felony? Yes/No If yes, please state the charge, date, county and state of the charge:_____
_____

Please list any social or recreational organizations/clubs in which you are a member: _____
_____

Please list any sports or social activities in which you participate on a regular basis: _____
_____

III. Bankruptcy

Have you ever filed for bankruptcy? Yes/No If yes, please give Date:_____ Place:_____

Do you anticipate the need to file bankruptcy in the foreseeable future? If yes, please explain:
_____

IV. Client Employment Information

Were you employed at the time of the accident? Yes/No
If no, please proceed to the next section (Medical Information).
If yes, please complete the following:

Employer: _____

Address: _____

Street *City* *State* *Zip*

Phone: _____ Job Title/Description: _____

Salary: $_____ hourly/weekly/monthly/yearly

Have you missed any time from work because of the injuries you suffered in the accident or do you anticipate missing time from work in the future? Yes/No
If no, please proceed to the next section (Medical Information)
If yes, please complete the following:

Employment start date: _____Date you were terminated, if applicable:_____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? Yes/No

If you are still unable to work because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) $_____

Did you file Federal Income Tax Returns for each year during the five years preceding this accident? Yes/No

Employment History

What other types of positions/jobs have you held in the past? _____
_____

Previous employers, dates of employment, salary: _____
_____
_____

Were you working a second job at the time of the accident? Yes/No
If no, please proceed to the next section (Medical Information).
If yes, please complete the following:

Second Employer: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Job Title/Description: _____

Second job salary: $_____ hourly/weekly/monthly/yearly

Employment start date:_____Date you were terminated, if applicable:_____

Date last worked: _____ Number of days missed since accident: _____

Date returned to work: _____ Are you able to do the same job? Yes/No

If you are still unable to work your second job because of your injuries, at what rate does your *net* wage loss continue to accrue per week (weekly earnings less any wage benefits which you are receiving) $_____

V. Medical Information

Injuries/Conditions (Current and Past)

Description of injuries: _____
_____

Were you hospitalized? Yes/No If yes, how many days? _____

Have you had any significant medical problems in the past? Yes/No If yes, please explain: ___
_____
_____

Please check which of the following complaints/symptoms you experienced *prior* to this accident and whether you treated with a physician for the complaints:

	Condition	*Treated with Physician*	*Physician Name, City, State*
____	neck pain	Yes/No	_____
____	back pain	Yes/No	_____
____	jaw pain	Yes/No	_____
____	headaches	Yes/No	_____
____	shoulder pain	Yes/No	_____
____	hip pain	Yes/No	_____
____	arthritis	Yes/No	_____
____	fibromyalgia	Yes/No	_____

Have you previously been injured in an automobile accident, work-related accident, fall or any other type of accident? Yes/No If yes, please provide the following information:

Date of Accident *Type of Accident* *City/State* *Injuries*

_____
_____
_____

Has a physician placed you at "maximum medical improvement? (MMI) for the injuries suffered in this accident? Yes/No/Unknown If yes, name of physician: _____
Any percentage of impairment, if known: _____%

Please list any restrictions which your physician has imposed because of your injuries (i.e. lifting, bending, etc): _____
_____

Loss of Consortium: Yes/No

Do you have photographs depicting your injuries? Yes/No

Health insurance coverage

Primary insurance company: _____

Address:_____

Telephone:_____ Policy No.: _____

Secondary insurance company:_____

Address:_____

Telephone:_____ Policy No.: _____

Medical Treatment (Current and Past)

Please list below the name, city and state of all medical providers who have treated or examined you relative to your injuries:

Ambulance: _____

Hospital – Emergency Room only: _____

Hospital – Admitted: _____

Primary treating physician: _____

Chiropractor: _____

*Orthopedist:*_____

*Neurologist:*_____

Neurosurgeon: _____

*Physiatrist (Physical Medicine/Rehabilitation):*_____

*Physical Therapy Facilities:*_____

*MRI/Diagnostic Testing Centers:*_____

*Other:*_____

Have you ever treated with a chiropractor? Yes/No Is yes, please provide the date of treatment, and name and address of chiropractor:_____
_____
_____

Please provide the name, city and state of all physicians with whom you have consulted AND all hospitals where you have been treated, **other than for this accident, within the past ten (10) years:**
_____
_____
_____
_____
_____
_____

VI. Accident Information

Date of incident: _____ Time of incident: _____AM/PM

Location of incident: _____
City State County

How did the incident happen? _____
_____
_____

Describe lighting conditions when the incident occurred (i.e. daylight, dark, artificial lighting, etc): _____

What type of shoes were you wearing at time of incident? _____

Were there any warnings posted at the site where the incident occurred (i.e. signs, barricades, orange cones, etc)? Yes/No If yes, please describe: _____
_____

Are you aware of any changes which have been made to the site of the incident to improve conditions (i.e. warnings added, improved lighting, etc)? Yes/No/Unknown If yes, please describe any changes: _____
_____

Were you carrying anything at the time of the incident? Yes/No If yes, describe the item(s) you were carrying: _____

How long had you been on the premises prior to the incident? _____

Were there any distractions at the site of the incident (i.e. pedestrian or vehicle traffic)? Yes/No
If yes, please describe: _____

What do you feel were the problems with the site of the incident or what conditions do you feel contributed to the incident? _____
_____

Do you know how long before your incident the condition which caused your accident existed? Yes/No If yes, please explain:_____

Did you consume any alcohol prior to the incident? Yes/No If yes, please provide the amount consumed and the time consumed: _____

Eyewitness(es) name/address: _____
_____

Was an incident report prepared? Yes/No/Unknown If yes, by whom? _____

Do you have photographs of the site of the incident? Yes/No

Primary defendant information

Name/Address of at-fault party: _____
_____

Relationship of at-fault party to the premises: _____

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage:	Bodily Injury Liability (BI)	Yes/No/Unknown	Limits:_____
	Medical Payments	Yes/No/Unknown	Limits:_____

Secondary defendant information

Name/Address of at-fault party: _____
_____

Relationship of at-fault party to the premises: _____

Insurance Company _____

Address _____

Telephone _____ Adjuster, if known _____

Policy # _____ Claim #, if known _____

Coverage:	Bodily Injury Liability (BI)	Yes/No/Unknown	Limits:_____
	Medical Payments	Yes/No/Unknown	Limits:_____

VII. Additional Information/Comments

_____
_____
_____
_____
_____
_____