WALSTEAD MERTSCHING
— ATTORNEYS AT LAW —

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PERSONAL INJURY FACT SHEET

Date: _____ Referred by: _____

FOR OFFICE USE ONLY

Disposition:

_____ (A) Conflict check
Date_____ Initials_____

_____ (B) Appointment scheduled with: Attorney: _____
Date and time: _____

_____ (C) Referred to _____

_____ (D) Check with _____

Attorney comments:_____

_____ (E) Client will call us back if they want to make appointment

_____ (F) Other: _____

A. PARTIES

Name:_____

Street address:_____

Mailing address (if different than above):_____

Phone:_____ / _____ / _____
home work cell

Email:_____

DOB:_____ SSN:_____

Marital status:_____ Spouse's name:_____

Children's names/ages:_____

_____

Adverse party's name:_____

Address:_____

Phone:_____

B. FACTS

Accident date:_____ Hour of day:_____ G a.m. G p.m.

Location:_____
(Street / Highway / Road/Mile Post Number)

County:_____ City:_____ State:_____

Description of incident:_____

_____

_____

_____

_____

Citations:_____

C. WITNESSES

Responding Police Agency:_____

Witnesses (name/address/phone):_____

_____

_____

_____

_____

_____

D. MEDICAL HISTORY

Injuries from incident:_____

_____

Current symptoms:_____

_____

Prior similar injuries (accidents/ L&I claims):_____

_____

Prior major medical conditions:_____

_____

Family doctor:_____ How long?_____

E. MEDICAL TREATMENT

Ambulance:_____

Emergency room:_____

Hospitals:_____

Primary doctor:_____

Consulting doctors:_____

Physical therapy:_____

Chiropractor/Massage:_____

Radiologist:_____

Pharmacy:_____

F. INSURANCE

1. **Liability**:_____ Adjuster:_____

   Address:_____

   Phone:__(_____)_____

   Their insured:_____ Claim no.:_____

   Policy limits:_____

2. **PIP/UIM**:_____ Adjuster:_____

   Address:_____

   Phone:__(_____)_____

   Their insured:_____ Claim no.:_____

   PIP limits:_____ PIP coverage:_____ _____

   Year(s) Date Ends

   UIM limits:_____

3. **Private Medical**:_____Adjuster:_____
Address:_____
Phone:__(_____)_____
Named insured:_____ Claim no.:_____
Medicare?(y/n)_____
Medicaid?(y/n)_____

G. STATEMENTS

Have you given anyone a signed or recorded statement? G Yes G No

If so, to whom?_____

H. EMPLOYMENT

Employer (name/address/phone):_____

_____

Supervisor:_____ Your position/title:_____

Rate of pay: $_____ How long employed?:_____

Have you missed any work? G Yes G No If so, how many hours?_____

Is additional time loss anticipated? G Yes G No Explain:_____

_____

I. DOMESTIC/CHORE SERVICES

Are you presently using services? G Yes G No

If so, from whom, when, for what service, rate of pay, time needed?:_____

_____

J. PROPERTY DAMAGE/CAR RENTAL/LOSS OF USE

Vehicle:_____ License no.:_____

Damage/Estimate:_____

Photographs:_____

Paid:_____ Date of payment:_____

Where stored:_____

Are storage charges accumulating? G Yes G No Rate:_____

Rental vehicle used? G Yes G No Dates of rental use:_____

Rental agency:_____

Vehicle totaled? G Yes G No If not, what is the cost of repair? $_____

If totaled: FMV $_____ Explanation:_____

If totaled, do you want to keep vehicle? G Yes G No

Deductible:_____

K. **SETTLEMENT OFFER**

G Yes G No If yes, how much? $_____

TELL CLIENT TO BRING IN TO APPOINTMENT:

1. **List of Health Care Providers**
2. **Auto Insurance Card/Policy**
3. **Health Insurance/Medicare/Medicaid Card**
4. **Police Report**
5. **Vehicle/injury Photos**
6. **Repair Estimates/Bills**
7. **Medical Records and Bills**