PADILLA & ASSOCIATES, PLLC

Personal Injury Questionnaire
For
Auto, Truck and Motorcycle Accidents

Our Personal Injury Practice Group has prepared this questionnaire to help you organize the information needed to advance a claim for personal injuries or property damage stemming from an auto, truck or motorcycle accident.

It is important that this questionnaire be filled out and sent to us immediately after the accident because some claims may need to be filed in as little as 30 days following the accident.

CLIENT INFORMATION:

Name: ____

Address: ____

____

Telephone: Work: ______________________________

Home: ______________________________

Cell: ______________________________

E-mail: Work: ______________________________

Home: ______________________________

Date of Birth:__________________ Social Security #:______________

School Name/Address:____

Employer Name/Address/Tel. Number:__________________________

____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No

If yes:

1. Child's Name:____________________ Age:__________

Lives with You? ☐ Yes ☐ No

If not, child's address:________________________________

2. Child's Name:____________________________ Age:_______________

Lives with You? ☐ Yes ☐ No

If not, child's address:____

3. Child's Name:____________________________ Age:_______________

Lives with You? ☐ Yes ☐ No

If not, child's address:____

4. Child's Name:____________________________ Age:_______________

Lives with You? ☐ Yes ☐ No

If not, child's address:____

ACCIDENT SCENE INFORMATION:

Date/Time of Accident: ____

Location of Accident: ____

Weather Conditions: ____

Road Conditions: ____

Traffic Conditions: ____

Lighting Conditions: ____

Other Accident Scene Information:____

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____

Traffic Control Devices at Scene (Traffic lights, posted signs, etc.): ______

____

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ACCIDENT INFORMATION:

Description of Accident:____

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Persons Involved in Accident:

Name	Involvement
Ex. John Doe	*Driver of Oldsmobile*
Jane Smith	*Motorcycle Passenger*
1. ____________	____________
2. ____________	____________
3. ____________	____________
4. ____________	____________
5. ____________	____________

Vehicles Involved in Accident:

Vehicle/License Plate	Insurance Information
Ex. Blue BMW (KJY-744)	*Allstate (Policy #XYZ-908765)*
1. ____________	____________
2. ____________	____________
3. ____________	____________
4. ____________	____________
5. ____________	____________

Emergency Responders Arriving at Scene:

☐ Police Dept. ☐ Fire Dept. ☐ None ☐ Other:____________

For each emergency responder, set forth as much information as possible such as name, precinct/company information, badge number, etc.):____

____

____

Report Prepared by Emergency Responder: ☐Yes ☐ No ☐ Not Sure

If yes, report prepared by: ☐Police Dept. ☐ Fire Dept. ☐ Other

Do you have a copy of the report? ☐ Yes ☐ No

If yes, please attach report to questionnaire.

VISUAL/DOCUMENTARY EVIDENCE:

Photos of Accident Scene: ☐ Yes ☐ No ☐ Pending

Photos of Vehicles Involved: ☐ Yes ☐ No ☐ Pending

Accident Report(s) Prepared by Non-Emergency Responders (for example, by an insurance company): ☐ Yes ☐ No ☐ Not Sure

If yes, report number(s):____________________________________

If yes, report prepared by:___________________________________

Do you have a copy of the report? ☐ Yes ☐ No

If yes, please attach report to questionnaire.

WITNESS INFORMATION:

1. Name: ____

Address: ____

Telephone: Work: ____________________________________

Home: ____________________________________

Cell: ____________________________________

Witness Summary [general description of witness, location of witness at time of accident, summary of statements made by witness at scene]: ____

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2. Name: ____

Address: ____

Telephone: Work: ____________________________________

Home: ____________________________________

Cell: ____________________________________

Witness Summary [general description of witness, location of witness at time of accident, summary of statements made by

witness at scene]: ____

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3. Name: ____

Address: ____

Telephone: Work: ______________________________

Home: ______________________________

Cell: ______________________________

Witness Summary [general description of witness, location of witness at time of accident, summary of statements made by witness at scene]: ____

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4. Name: ____

Address: ____

Telephone: Work: ______________________________

Home: ______________________________

Cell: ______________________________

Witness Summary [general description of witness, location of witness at time of accident, summary of statements made by witness at scene]: ____

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5. Name: ____

Address: ____

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Telephone: Work: ____________________________________

Home: ____________________________________

Cell: ____________________________________

Witness Summary [general description of witness, location of witness at time of accident, summary of statements made by witness at scene]: ____

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MEDICAL DAMAGES:

Physical Injuries:

Did you receive medical attention at the scene: ☐ Yes ☐ No

Describe injuries sustained in the accident:______________________

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Hospital/Medical Providers:

Name	Address/Tel. Number
1. ______________________	____________________________________
	____________________________________
	Date(s of Treatment:________________
2. ______________________	____________________________________
	____________________________________
	Date(s of Treatment:________________

3. ____________________ ________________________________

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Date(s of Treatment:______________

4. ____________________ ________________________________

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Date(s of Treatment:______________

Medical/Diagnostic Testing:

Blood Test: ☐ Yes ☐ No

If yes, who administered test?____________________________

If yes, where was test administered?______________________

Urine Test: ☐ Yes ☐ No

If yes, who administered test?____________________________

If yes, where was test administered?______________________

Breathalyzer Test: ☐ Yes ☐ No

If yes, who administered test?____________________________

If yes, where was test administered?______________________

X-rays: ☐ Yes ☐ No

If yes, who took the x-rays?______________________________

If yes, where were x-rays taken?___________________________

MRI: ☐ Yes ☐ No

If yes, who performed MRI?_______________________________

If yes, where was test performed?__________________________

CT Scan: ☐ Yes ☐ No

If yes, who performed CT Scan?____________________________

If yes, where was test administered?______________________

Other (Describe Test):_____________________________________

If yes, who performed the test?____________________________

If yes, where was the test performed?______________________

FINANCIAL DAMAGES:

Lost Earnings:

Employer Name/Address on Date of Accident:____________________

____

Time Missed from Work:____

Salary on Date of Accident:___________________________________

Union Member: ☐ Yes ☐ No

If yes, union name/address/telephone number:______________

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If yes, union title/designation:__________________________

If yes, year joined union:_______________________________

If yes, benefits lost due to accident:_____________________

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Property Damage:

List all items damaged and estimated cost of damage:_____________

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Out-of-Pocket Expenses:

List all out-of-pocket expenses (retain all receipts):______________

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MISCELLANEOUS INFORMATION:

Other Information Relevant to the Accident:______________________________

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If you have any questions about an accident you have been involved in, please contact us <u>immediately</u> at (646) 290-5168 for a detailed explanation of your rights. Remember, depending on the type of accident, some legal papers may need to be filed in as little as 30 days!

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