

**PADILLA & ASSOCIATES, PLLC**

**Personal Injury Questionnaire  
For  
Construction 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 a construction 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: \_\_\_\_\_

Location of Accident Open to the Public:  Yes  No

Owner of Property: \_\_\_\_\_

Property is a 1 or 2 Family Dwelling:  Yes  No

General Contractor: \_\_\_\_\_

Project Manager: \_\_\_\_\_

Site Safety Inspector: \_\_\_\_\_

Site Supervisor/Superintendent: \_\_\_\_\_

Weather Conditions: \_\_\_\_\_

Lighting Conditions: \_\_\_\_\_

Other Accident Scene Information: \_\_\_\_\_

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

**ACCIDENT INFORMATION:**

Did Accident Involve a Fall from a Height:  Yes  No

If yes, how far did you fall? \_\_\_\_\_

Were Safety Devices Provided to you Prior to the Accident?  Yes  No

If yes, list all safety devices provided to you: \_\_\_\_\_

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If yes, did any safety devices fail?  Yes  No

If yes, list safety devices which failed: \_\_\_\_\_

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Activity Being Performed at Time of Accident: \_\_\_\_\_

Cause of Accident: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

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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.): \_\_\_\_\_

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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

Accident Report(s) Prepared by Non-Emergency Responders (for example, by an insurance company or General Contractor):  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]: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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]: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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]: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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]: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. 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]: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL DAMAGES:**

Physical Injuries:

Did you receive medical attention at the scene:  Yes  No

Describe injuries sustained in the accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospital/Medical Providers:

Name Address/Tel. Number

1. \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

2. \_\_\_\_\_

Date(s) of Treatment: \_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_  
Date(s) of Treatment: \_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_  
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: \_\_\_\_\_

\_\_\_\_\_

If yes, union title/designation: \_\_\_\_\_

If yes, year joined union: \_\_\_\_\_

If yes, benefits lost due to accident: \_\_\_\_\_

\_\_\_\_\_

Out-of-Pocket Expenses:

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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