

PADILLA & ASSOCIATES, PLLC

**Personal Injury Questionnaire
For
Elevator/Escalator 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 elevator or escalator 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: _____

Lighting Conditions: _____

Other Accident Scene Information: _____

ACCIDENT INFORMATION:

Accident Type: Elevator Escalator Other Mechanical Lift

Brand of Elevator/Escalator/Mechanical Lift: _____

Elevator/Escalator/Mechanical Lift: Automatic Manually Operated

Elevator/Escalator/Mechanical Lift Used by Public: Yes No

Inspection Certificate Visible: Yes No

Cause of Accident: _____

Description of Accident: _____

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

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]: _____

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): _____

