INITIAL INTAKE FORM

Client Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Employers Name: _____

Address: _____

_____

Time Lost: YES/ NO

Wages Per Week: _____

Date of Birth: _____

Social Security Number _____

Driver's License Number _____

State Issued: NJ / OTHER: _____

Marital Status: SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED

Name of Spouse: _____

Children: _____

_____

_____

Prior Accident: YES / NO

Date of Prior Accident: _____

Injuries Sustained: _____

_____

_____

Attorney Settled for: $_____

CURRENT ACCIDENT

Date of Accident: _____

Time: _____

Location: _____

Weather: _____

Description of Accident: _____

_____

_____

_____

_____

_____

Speed: _____

Did you observe the other vehicle? _____

_____

_____

Ambulance: YES / NO

Hospital: _____

Injuries:

Treating Physicians:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Primary Care Physician: _____

PIP/UM/UIM Insurance: _____

Liability Insurance: _____

Health Insurance: _____

Threshold: _____

Photos: YES / NO

Property Damage: _____

_____

_____

_____

Wearing Seatbelt: YES / NO

Witnesses: _____

_____

_____

COMMENTS: