NOLAND LAW FIRM, LLC

Confidential Personal Injury Questionnaire

34 Westwoods Drive
Liberty, Missouri 64068
Phone: (816) 781-5055
Fax: (816) 781-5216
www.nolandlawfirm.com

Noland Law Firm, LLC
-2010-

INSTRUCTIONS

Please answer the following questions as fully and accurately as possible. A full and complete disclosure is critical. The following information will be needed in order to properly advise you and handle your case. Please print and fill out every applicable question. If a question is not applicable, please write N/A in the space. Do not leave blanks. This information will help us help you. This information will be kept confidential.

If you need more space, please attach another sheet and clearly indicate which question you are answering. If you are not certain about an answer, leave the space blank. If any question is not applicable, write “N/A” in the blank. You may wish to make a copy to retain for your own records.

You need to keep attorney advised as to your current address and phone number(s).

Any of the information provided to us by you in this questionnaire will be held in the strictest confidence by the Noland Law Firm, LLC.

CLIENT INFORMATION

1. BACKGROUND:

FULL NAME: ____

ADDRESS: _______________________ CITY______________ STATE: _____ ZIP_______

PHONE: (H) ____________________ (W) _________________ OTHER _______________

CELL:_____________________________ EMAIL:________________________________

SOCIAL SECURITY NUMBER: ____

DATE OF BIRTH: ____

PLACE OF BIRTH: ____

EDUCATION: ____

MARITAL STATUS: (M) (S) (D) ____

PRIOR MARRIAGES, IF SO LIST:____

HAVE YOU EVER BEEN KNOWN BY ANY OTHER NAMES, IF SO LIST:_____________

____

2. SPOUSE'S BACKGROUND:

FULL NAME: ____

ADDRESS: _______________________ CITY______________ STATE: _____ ZIP_______

PHONE: (H) ____________________ (W) _________________ OTHER _______________

CELL:_____________________________ EMAIL:________________________________

SOCIAL SECURITY NUMBER: ____

DATE OF BIRTH: ____

PLACE OF BIRTH: ____

EDUCATION: ____

3. PERSON WHO WILL ALWAYS KNOW YOUR WHEREABOUTS:

NAME: ___________________________________ RELATIONSHIP: ______________________

ADDRESS: _________________________ CITY________________ STATE: _____ ZIP_______

PHONE: (H) ______________________ (W) ___________________ OTHER _________________

4. WHO REFERRED YOU TO OUR OFFICE? _________________________________

5. STATE THE ADDRESSES WHERE YOU HAVE RESIDED DURING THE LAST 10 YEARS AND THE PERIOD OF TIME YOU RESIDED THERE.

ADDRESS	WHEN RESIDED THERE
____	_________________________
____	_________________________
____	_________________________
____	_________________________

6. CHILDREN:

PLEASE FURNISH FULL NAME, ADDRESS, BIRTH DATE AND AGE OF ALL CHILDREN:

FULL NAME:____

PRESENT ADDRESS:____

DATE OF BIRTH:____

AGE:____

FULL NAME:____

PRESENT ADDRESS:____

DATE OF BIRTH:____

AGE:____

FULL NAME:____

PRESENT ADDRESS:____

DATE OF BIRTH:____

AGE:____

7. ACCIDENT INFORMATION FOR THIS CLAIM:

DATE OF ACCIDENT/OCCURRENCE:____

TIME OF ACCIDENT/OCCURRENCE: ____

LOCATION OF ACCIDENT/OCCURRENCE:____

ADDRESS: ________________________ CITY __________ COUNTY ________ STATE ____

PARTS OF THE BODY INJURED/AFFECTED: _______________________________________

____

____

____

DESCRIBE HOW ACCIDENT HAPPENED:____

____

____

____

8. OTHER PARTY:

LIST THE NAME AND ADDRESS OF ALL PARTIES YOU BELIEVE ARE RESPONSIBLE FOR ANY INJURIES YOU SUFFERED:____

____

____

____

9. EMPLOYMENT INFORMATION:

EMPLOYER: ____

ADDRESS: ___________________________ CITY ___________ STATE _____ ZIP _______

TELEPHONE:__________ DATE OF HIRE: ________ LENGTH EMPLOYED:____________

JOB DUTIES:____

RATE OF PAY: (SALARY) __________________ (HRLY RATE)_______________________

(HRS PER DAY) ________________________ (DAYS PER WEEK) ____________________

(OVERTIME RATE) _____________________ (OVERTIME HOURS) __________________

(FRINGE BENEFITS) ____

(PART TIME) ____

10. LOST WAGES:

LOST TIME FROM WORK, RATE OF PAY AND, ESTIMATED LOST WAGES AND EXPLAIN HOW YOU HAVE CALCULATED THE SAME: ___________________________

____

LOSS OF BUSINESS PROFITS OR LOSS OF INCOME FROM OTHER SOURCES:

____

ARE YOU OR HAVE YOU RECEIVED DISABILITY BENEFITS AS A RESULT OF THIS ILLNESS OR INJURY? IF YES, PLEASE DESCRIBE: _____________________________

____

LIST YOUR PAST EMPLOYMENT FOR THE LAST 10 YEARS, INCLUDING NAME, PERIOD OF TIME EMPLOYED AND ADDRESS.___________________________________

____

____

____

____

11. HEALTH INSURANCE INFORMATION:

THE NAME OF YOUR PRIMARY/PRIVATE HEALTH INSURANCE CARRIER AND THE GROUP OR POLICY NUMBER OF SAME. ____

12. AUTO INSURANCE INFORMATION:

THE NAME OF YOUR AUTO INSURANCE CARRIER:______________________________

____

POLICY NUMBER: _______________________ COVERAGE: _________________________

LIABILITY LIMITS:____

MED PAY LIMITS: ____

UNINSURED MOTORIST LIMITS: ____

UNDERINSURED MOTORIST LIMITS: ____

13. OTHER ASSISTANCE:

ARE YOU A MEDICAID RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICAID NUMBER. ____

ARE YOU A MEDICARE RECIPIENT? IF YES, PLEASE PROVIDE YOUR MEDICARE NUMBER. ____

DO YOU RECEIVE SOCIAL SECURITY BENEFITS? IF SO, PLEASE STATE MONTHLY AMOUNT____

WERE MEDICARE OR MEDICAID BENEFITS PAID IN ASSOCIATION WITH THE BELOW LISTED MEDICAL TREATMENT? YES ______ NO _______

14. **LIST ALL MEDICAL TREATMENT YOU HAVE HAD AS A RESULT OF THIS OCCURRENCE:**

PLEASE LIST BELOW THE MEDICAL CARE PROVIDERS INVOLVED IN THE ABOVE INCIDENT/OCCURRENCE. ATTACH A SEPARATE SHEET IF NECESSARY.

HOSPITALS	ADDRESS	DATES OF SERVICES

DOCTORS	ADDRESS	DATES OF SERVICES

PHYSICAL THERAPY	ADDRESS	DATES OF SERVICES

PHARMACIES	**ADDRESS**	**DATES OF SERVICES**

MEDICAL DEVICES	**PRESCRIBED BY**	**PERMANENT/TEMP.**

15. WHAT ARE YOUR PRESENT COMPLAINTS? LIST EVERY COMPLAINT YOU HAVE.

____

____

____

____

____

16. **PRIOR ACCIDENTS AND INJURIES: LIST EVERY PRIOR ACCIDENT, CAR ACCIDENT, SLIP AND FALL, AND ANY OTHER ACCIDENT IN WHICH YOU HAVE RECEIVED MEDICAL CARE AND TREATMENT.**

DATE	INJURY	DOCTOR/HOSPITAL AND ADDRESS

17. **PRIOR HOSPITALIZATIONS: LIST EVERY TIME YOU HAVE EVER BEEN HOSPITALIZED.**

HOSPITAL	DATE	REASON

18. **HAVE YOU EVER BEEN A PARTY IN ANY PREVIOUS LAWSUITS (HAVE YOU EVER SUED OR BEEN SUED), OR MADE A CLAIM AGAINST ANYONE FOR DAMAGES? IF SO, PLEASE DESCRIBE IN DETAIL:**

____

____

____

____

____

19. HAVE YOU EVER BEEN ARRESTED OR CONVICTED OF A CRIMINAL OFFENSE? FELONY: YES ____ NO ____ MISDEMEANOR: YES ___ NO ____

IF YES, LIST: OFFENSE, DATE & JURISDICTION ____________________________________

____

20. HAVE YOU KEPT ANY DIARIES OR CALENDARS OF EVENTS ASSOCIATED WITH THIS ILLNESS OR INJURY? IF YES, PLEASE IDENTIFY: ____

____

____

21. HAVE YOU EVER FILED FOR BANKRUPTCY? YES ____ NO ____

______ **IF SO, WHEN?**

22. ARE YOU PLANNING OR CONSIDERING FILING FOR BANKRUPTCY IN THE NEXT 6 MONTHS? YES ____ NO ____

YOU MUST NOTIFY YOUR ATTORNEY IF YOU ARE CONSIDERING OR IF YOU OR YOUR SPOUSE FILE FOR BANKRUPTCY.

ANY OTHER INFORMATION YOU FEEL IMPORTANT AND WOULD LIKE TO PROVIDE:

____

____

____

____

____

____

____

____

DATE: ________________________ __________________________________
CLIENT

THIS INFORMATION IS CONFIDENTIAL AND ONLY FOR THE USE OF NOLAND LAW FIRM, LLC.

End of questionnaire