PERSONAL INJURY
CLIENT INTAKE QUESTIONNAIRE:

GET MEDICAL CARE FIRST. Deadlines can be short: claims against a government agency often must be filed within 6 months, and medical malpractice claims within 1 year of discovery. Do not give a recorded statement to the other side's insurer, sign a release, or post about the incident on social media until we speak.

CONFIDENTIAL. This questionnaire covers injuries or deaths caused by another person's or company's intentional, reckless, or negligent conduct. Please preserve all evidence (photos, damaged property, products, clothing, and records). If a question does not apply, write "N/A." If unknown, write "Unknown."

NAME OF THE CLIENT:

This form is completed by:

[__] The injured person [__] Parent / guardian of an injured minor

[__] Family member of a person who died [__] Other representative

[__] Your Full Legal Name: _____

Injured person's name (if different): _____ Date of Birth: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation / Employer: _____ Syndicate Plan Member ID: _____

Preferred method of contact:

[__] Phone [__] Text [__] Email

PART 1 — TYPE OF INJURY CLAIM

1.1 Check all that apply:

[__] Automobile / truck accident [__] Motorcycle / bicycle accident

[__] Pedestrian accident [__] Rideshare / bus accident

[__] Slip / trip & fall [__] Premises liability (unsafe property)

[__] Dog bite [__] Product defect

[__] Medical malpractice [__] Dental malpractice

[__] Nursing home abuse / neglect [__] Civil assault & battery

[__] Sexual battery [__] Wrongful death

[__] Injury on government property [__] Other

PART 2 — THE INCIDENT

2.1 Date: _____ Time: _____ Weather / lighting: _____

2.2 Location (address / intersection): _____

City: _____ County: _____ State: _____

2.3 Describe what happened: _____

_____

_____

_____

2.4 Were police or security called? [__] Yes [__] No

Agency and report number: _____

2.5 Was anyone cited or arrested? [__] Yes [__] No

If yes, explain: _____

_____

2.6 Do you have photos or video of the scene, injuries, or damage? [__] Yes [__] No

2.7 Is there security, dash-cam, or phone video that may exist? [__] Yes [__] No

If yes, explain: _____

_____

2.8 Witnesses:

Name	Phone / Email	What They Saw

PART 3 — WHO IS RESPONSIBLE?

Name (person / company / agency)	Role (driver, owner, business, doctor, maker)	Insurance Company	Claim No.

3.1 Is a government agency involved (city, county, state, transit)? [__] Yes [__] No

Claims against government agencies generally require a written claim to the agency within 6 months before a lawsuit can be filed.

3.2 Were you working at the time (on the job or driving for work)? [__] Yes [__] No

Workplace injuries may involve workers' compensation as well as claims against other responsible parties.

PART 4 — VEHICLE ACCIDENTS

4.1 You were the:

[__] Driver [__] Passenger [__] Pedestrian

[__] Bicyclist [__] Motorcyclist

4.2 Your vehicle (year / make / model): _____ Owner: _____

4.3 Your insurance company: _____ Claim No.: _____

4.4 Your coverage:

[__] Liability [__] Uninsured / underinsured motorist

[__] Medical payments [__] Collision

[__] Rental coverage [__] Not sure

4.5 Other driver / vehicle / plate: _____

4.6 Was the other driver working (delivery, rideshare, company vehicle)? [__] Yes [__] No

4.7 Estimated property damage: $ _____

PART 5 — INJURIES & MEDICAL TREATMENT

5.1 Injuries (check all that apply):

[__] Head / brain [__] Neck / back / spine [__] Broken bones

[__] Cuts / scarring [__] Burns [__] Internal injuries

[__] Emotional / psychological [__] Other

5.2 Describe your injuries and symptoms: _____

_____

5.3 Were you taken by ambulance or treated in an emergency room? [__] Yes [__] No

Doctor / Hospital / Clinic	Type of Treatment	Dates	Still Treating?

5.4 Who is paying for treatment?

[__] Private health insurance [__] Medicare [__] Medi-Cal / Medicaid

[__] Workers' comp [__] None

5.5 Did you have prior injuries or conditions in the same body parts? [__] Yes [__] No

If yes, explain: _____

_____

PART 6 — YOUR LOSSES

Loss	Amount $
Medical bills to date	
Estimated future medical care	
Lost wages to date	
Property damage	
Out-of-pocket costs (travel, help at home)	

6.1 Pay rate before injury: $ _____ Days / weeks missed from work: _____

6.2 How have the injuries affected your daily life, family, work, and activities? _____

_____

_____

PART 7 — MEDICAL / DENTAL MALPRACTICE

7.1 Provider / facility: _____

7.2 Date of treatment / procedure: _____ Date problem discovered: _____

7.3 What went wrong? _____

_____

_____

7.4 Doctors who treated you afterward: _____

Malpractice claims have special deadlines and notice requirements. Nursing home cases: please also complete our Elder Law Intake Form.

PART 8 — WRONGFUL DEATH

8.1 Name of person who died: _____ Date of death: _____

8.2 Your relationship: _____ Cause of death: _____

Surviving Spouse / Children / Heirs	Relationship	Age	Financially Dependent?

8.3 Has a probate estate been opened? [__] Yes [__] No

PART 9 — INSURANCE CONTACT & PRIOR ACTION

9.1 Has any insurance company contacted you? [__] Yes [__] No

9.2 Did you give a recorded or written statement? [__] Yes [__] No

9.3 Have you received a settlement offer or signed a release? [__] Yes [__] No

If yes, explain: _____

_____

9.4 Have you hired or spoken with another lawyer about this incident? [__] Yes [__] No

If yes, explain: _____

_____

PART 10 — DOCUMENTS & AUTHORIZATION

Please provide copies of the following, if available. Check each item you are including.

[__] Police / incident report

[__] Medical records & bills

[__] Auto insurance policy

[__] Proof of lost wages

[__] Death certificate (wrongful death)

[__] Photos / videos

[__] Health insurance card

[__] Claim letters from insurers

[__] Repair estimates

[__] Product / packaging (keep safely)

[__] I authorize Syndicate Subscription Legal Plans to request my medical, employment, and insurance records and communicate with insurers and responsible parties regarding this matter.

Certification:

I declare that the information provided in this questionnaire is true, correct, and complete to the best of my knowledge. I understand this information is provided to Syndicate Subscription Legal Plans in confidence for the purpose of evaluating my personal injury matter.

Signed and dated this ____ day of _____, 20___

Signature: _____

Print Name: _____

Please Print and Email to STEVE@STEVEMUELLERLEGAL.COM, or save this document as a PDF and email to STEVE@STEVEMUELLERLEGAL.COM,
Your information will be reviewed within one hour.