LAW OFFICES OF

JAMES H. MAGEE

James H. MaGee

Phone:
(253) 383-1001
Facsimile:
(253) 383-2813

Physical Address:
1108 N 6th Street
Tacoma, WA 98403

Mailing Address:
Post Office Box 1132
Tacoma, WA 98401-1132

Appointment Date:

Appointment Time:

OFFICE USE ONLY

DOCUMENTS TO BRING TO INITIAL MEETING

1. Current medical records, bills, and photographs
2. Current medical orders, physical therapy orders, and prescriptions
3. Last 3 months pay stubs
4. Last 2 years income tax returns
5. Insurance policy, including declaration page
6. Proof of hours missed from work (ex. timecards)
7. Names of persons spoken to about accident
8. Any vehicle repair estimates you have obtained because of this accident.

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PERSONAL INJURY FEE AGREEMENT

Date:_______________

The undersigned, hereinafter called "Clients" hire James H. MaGee hereinafter called "Attorney" regarding a claim for damages due to injuries to ______________________ occurring approximately on ______________20__ and mutually agree as follows:

1. **Initial Evaluation:** Clients agree to pay the costs of having an expert evaluate this case and obtaining the necessary records to do so. Clients agree to deposit $_________ to apply upon such costs. Any balance remaining shall be refunded to the client if attorney does not accept this case. No fee will be charged by attorney for this evaluation.

2. **Costs:** Clients understand that there will be costs incurred in addition to attorney's fees. Clients agree to pay such costs advanced by attorney. Clients understand attorney employs an investigator full time and they will be billed at an hourly rate for work done by such investigator.

3. **Copies:** Attorney will provide clients with copies of material attorney believes to be significant relating to clients case. Clients agree to pay attorney for copying such material.

4. **Monthly Billing:** Clients will receive a monthly billing on costs advanced. Clients agree to pay interest on the unpaid balance at 12% per annum.

5. **Attorney's Fees:** Clients agree to pay attorney 33 1/3% of all money collected on clients' behalf, as a result of this claim as attorney's fees computed before deduction of costs. If payment to client is on the basis of an annuity payment over a period of time, then the client agrees to pay attorney 33 1/3% of the present value of the total payments which fee shall be collected from the cash paid at the time of recover. NO ATTORNEY'S FEES SHALL BE PAID IF NO MONEY IS RECOVERED FOR CLIENT. Costs, however, shall be paid in addition to the fee whether or not money is recovered

for client. Attorney shall pay any associate from attorney's fee at no additional cost to client.

6. **Arbitration or Trial:** If this case goes to arbitration by any party, or trial, the attorney's fee shall be 40% of the total recovery as set forth in the previous paragraph as of the date of filing.

7. **Appeal:** If this case is appealed by any party, the attorney's fee shall be 45% of the total recovery as set forth in the previous paragraph as of the date of filing the notice of appeal.

______________________________ ______________________________

James H. MaGee **Client**

Attorney at Law

1530 S. Union Street; Suite 9 ______________________________

Tacoma WA 98405 **Client**

253/383-1001

AUTHORIZATION FOR RELEASE FOR MEDICAL INFORMATION TO ATTORNEY

RE: ____

To Whom It May Concern:

This is to authorize any physician, hospital, laboratory or health care provider of any kind to furnish to my attorney, James H. MaGee, PO Box 1132, Tacoma, Washington 98401, Phone 253/383-1001, any medical information whatsoever regarding myself or my minor child or children. This release of information is to allow my attorney or any representative on their behalf authorized by them to obtain any and all information or opinions, to see or copy any x-ray, hospital records, physician's records or any other material, and I do hereby waive any physician/patient privilege in this regard.

1. **Duration of Waiver:** This authorization shall be valid for a period of three (3) years or until advised in writing by me of its revocation before the expiration of three (3) years from date hereof.

2. **Copy in Lieu of Original:** A copy of the original authorization for release of medical information shall have the same force and effect as the signed original.

3. **Unlawful Disclosure Prohibited:** YOU ARE HEREBY NOTIFIED THAT STATE LAW PROHIBITS ANY PHUSICIANS, HOSPITAL OR HEALTH CARE PROVIDER FROM RELEASING ANY INFORMATION ABOUT THE PATIENT TO SOME OTHER PERSON UNLESS THE PATIENT FIRST CONSENTS TO THE RELEASE OF THE SAME. THE UNAUTHORIZED RELEASE OF INFORMATION ABOUT A PATIENT CAN RESULT IN THE LOSS OF THE PATIENT'S LEGAL RIGHTS AND RESULT IN A DAMAGE CLAIM FOR SUCH UNAUTHORIZED RELEASE. THEREFORE, YOU ARE HEREBY DIRECTED NOT TO RELEASE ANY INFORMATION OF ANY NATURE WHATSOEVER TO INSURANCE ADJUSTERS, ATTORNEYS OR THEIR REPRESENTATIVES OR ANY OTHER PERSONS WHO MAY CONTACT YU OR YOUR OFFICE STAFF ABOUT THIS PATIENT UNLESS WRITTEN CONSENT HAS BEEN GIVEN BY THE PATIENT FOR THE RELEASE OF SUCH INFORMATION. You are authorized,

however, to release medical information to the patient's medical insurance carrier or the Department of Labor and Industries as provided in the next paragraph.

4. **Medical Insurance:** You are authorized to release medical information to the patient's own medical insurance company or the Department of Labor and Industries in order to see that you bill or treatment is paid or reimbursed.

5. **Revocation of Other Waivers:** I hereby revoke any other authorization for release of medical information, which may have been provided to you by any insurance adjustor or insurance company other than my medical insurance company of the Department of Labor and Industries.

6. **Caution:** PLEASE ALERT YOUR STAFF AS TO THE RESTRICICITION OR RELEASE OF INFORMATION OF ANY NATURE WHATSOEVER REGARDING THIS PATIENT TO PERSONS UNAUTHORIZED TO RECEIVE THE SAME IN ORDER TO AVOID POSSIBLE LEGAL COMPLIACATIONS.

Dated: ________________________ ___________________________

Patient

____

Patient

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Name: ______________________________ Date: ________________20__________

Address: ____

To Whom It May Concern:

THE UNDERSIGNED does hereby certify that James H. MaGee, Attorney at Law, PO Box 1132, Tacoma, Washington 98401, Phone 253/383-1001 does hereby represent me as my attorney. I have authorized my attorney, or any representatives of their office, to obtain information regarding me, and hereby acknowledge as follows:

1. **Extent of Authorization:** This authorization and release shall apply to myself, or the person whose name appears above, any child of mine, or any person for who I am responsible for their care, custody and control. All provisions of this authorization shall apply to such persons.

2. **Waiver of All Privilege:** I hereby waive any and all privilege of any kind, which I may legally possess regarding any information of any nature whatsoever that me be requested by my attorneys or their representatives.

3. **General Information Authorization:** I hereby authorize any person to provide my attorney, or any representative from his offices, all information of every nature requested by them.

4. **Employment Information:** I hereby authorize any employer or anyone on behalf of such employer, past or present, to release to my attorneys or their representatives any information of any nature in that regard. I hereby waive any privilege or legal confidentiality in that regard.

5. **School Information:** I hereby authorize any school of any nature whatsoever to release to my attorneys or a representative from their office any and all information of every kind, including personnel files, grades, intelligence testing or psychological testing, teacher evaluation, confidential information, medical information, and all other information, which may be in the possession of such school.

6. **Revocation of Other Waivers:** I hereby revoke any other waivers or authorizations, which I may have given to my employer, or any other person, to obtain information of any nature regarding me, or for the release of information regarding me, except to my attorneys or their representatives. You are hereby requested not to release or disclose any information to any insurance company or other person without my written permission from this date forward.

7. **Copy of Release:** A copy of this release shall have the same force and effect as a signed original would have.

8. **Duration of Waiver:** This waiver shall remain in full force and effect and shall be valid for a period of three years from the date hereof, after which it shall automatically be revoked without further notice. Until the expiration of such three years, it shall remain in full force and effect.

9. **Reason for Release:** No reason need be given by my attorneys or their representatives for the release of such information and I authorize such release without any reasons being given for requesting same.

WITNESS__________________________**SIGNED** _____________________________

PLAINTIFF'S INITIAL INTERVIEW REPORT

Referred by: ____________________________ Date:________________________

CLAIMANT:
Name: ________________________________ Phone: ______________________
Address:____
Date of Birth: ______________________ Age: _____ Spouse: ____________________
Children: ____
Employer: _______________________ Address: _________________________________

DEFENDANT:
Name: ________________________________ Phone: ______________________
Address: ______________________________ Age: _________
Spouse: _______________________________ Employer: ___________________

DEFENDANT'S INSURANCE:
Insurance Company: ____
____
Limits: _____________________________
Adjustor: ___________________________

PLAINTIFF"S INSURANCE:
Insurance Company: ____
____
Adjustor: _________________________
Collision? _______ Ded Amount $_________Med Pay? _______ Claim Made? ______
Comments: ____
____

Facts:
Date: _________ Day: ________ Time: _______ Weather: ______________________
County: _____________________ Location: ___________________________________
Location of Plaintiff's Vehicle: ____
Location of Defendant's Vehicle: ____
Draw diagram of accident on last page:

Doctors and Hospitals:

Treating Doctor(s) ________________________ Address:___________________________

________________________ Address:___________________________

________________________ Address:___________________________

Others Consulted: ____

____

Initial Hospital: ___________________________ Address:__________________________

Other Hospital: ___________________________ Address: __________________________

Injuries:

Injuries sustained: ____

Doctor's advice regarding injuries: ____

____

OUT-OF-POCKET EXPENSES:

1. Physicians: ____________________ Amount $____________ Paid $____________

2. Hospitals: ____________________ Amount $____________ Paid $____________

3. Ambulance: ____________________ Amount $ ___________ Paid $____________

4. Nurses: _______________________ Amount $____________ Paid $____________

5. Drugs: ________________________ Amount $ ____________ Paid $____________

6. Crutches, braces, etc. ___________ Amount $_____________ Paid $____________

7. X-Rays ________________________ Amount $ _____________ Paid $____________

8. Domestic Help: _________________ Amount $ _____________ Paid $ ___________

9. Auto Repair: ___________________ Amount $ _____________ Paid $ ___________

10. Car Rental: ___________________ Amount $ _____________ Paid $ ___________

11. Lost Wages: __________________ Amount $ _____________ Paid $ ___________

12. Other: _______________________ Amount $ _____________ Paid $ ___________

Witnesses:

Police Officer: Name:____

Other Witnesses:

Name and Address: ____

____

Name and Address: ____

____

Name and Address: ____

____

Statements given to Insurance Adjusters? ________________________, If so, signed?
Which Adjuster? ____

Client Impression:
Appearance: Good _______ Average _______ Poor _______ Believable _______
Unbelievable _______ General Impression: __________________________________

Settlement Offers:
Settlement offer before referral : Offer Received: $ ____________________
How given (writing, oral, etc.): ____________________________________
Remarks: ____

____

____

____

Was Client wearing seatbelts? Yes ______ No ______

Draw Diagram of Accident Here:

AUTHORIZATION FOR RELEASE FOR MEDICAL INFORMATION TO ATTORNEY

RE: ____

To Whom It May Concern:

This is to authorize any physician, hospital, laboratory or health care provider of any kind to furnish to my attorney, James H. MaGee, PO Box 1132, Tacoma, Washington 98401, Phone 253/383-1001, any medical information whatsoever regarding myself or my minor child or children. This release of information is to allow my attorney or any representative on their behalf authorized by them to obtain any and all information or opinions, to see or copy any x-ray, hospital records, physician's records or any other material, and I do hereby waive any physician/patient privilege in this regard.

7. **Duration of Waiver:** This authorization shall be valid for a period of three (3) years or until advised in writing by me of its revocation before the expiration of three (3) years from date hereof.

8. **Copy in Lieu of Original:** A copy of the original authorization for release of medical information shall have the same force and effect as the signed original.

9. **Unlawful Disclosure Prohibited:** YOU ARE HEREBY NOTIFIED THAT STATE LAW PROHIBITS ANY PHYSICIANS, HOSPITAL OR HEALTH CARE PROVIDER FROM RELEASING ANY INFORMATION ABOUT THE PATIENT TO SOME OTHER PERSON UNLESS THE PATIENT FIRST CONSENTS TO THE RELEASE OF THE SAME. THE UNAUTHORIZED RELEASE OF INFORMATION ABOUT A PATIENT CAN RESULT IN THE LOSS OF THE PATIENT'S LEGAL RIGHTS AND RESULT IN A DAMAGE CLAIM FOR SUCH UNAUTHORIZED RELEASE. THEREFORE, YOU ARE HEREBY DIRECTED NOT TO RELEASE ANY INFORMATION OF ANY NATURE WHATSOEVER TO

INSURANCE ADJUSTERS, ATTORNEYS OR THEIR REPRESENTATIVES OR ANY OTHER PERSONS WHO MAY CONTACT YOU OR YOUR OFFICE STAFF ABOUT THIS PATIENT UNLESS WRITTEN CONSENT HAS BEEN GIVEN BY THE PATIENT FOR THE RELEASE OF SUCH INFORMATION. You are authorized, however, to release medical information to the patient's medical insurance carrier or the Department of Labor and Industries as provided in the next paragraph.

10. **Medical Insurance:** You are authorized to release medical information to the patient's own medical insurance company or the Department of Labor and Industries in order to see that your bill or treatment is paid or reimbursed.

11. **Revocation of Other Waivers:** I hereby revoke any other authorization for release of medical information, which may have been provided to you by any insurance adjustor or insurance company other than my medical insurance company or the Department of Labor and Industries.

12. **Caution:** PLEASE ALERT YOUR STAFF AS TO THE RESTRICICITION OR RELEASE OF INFORMATION OF ANY NATURE WHATSOEVER REGARDING THIS PATIENT TO PERSONS UNAUTHORIZED TO RECEIVE THE SAME IN ORDER TO AVOID POSSIBLE LEGAL COMPLIACATIONS.

Dated: ________________________ ___________________________

Patient

____

Patient

ADULT PERSONAL INJURY CLIENT REPORT

A. Information about client:

1. Your Full Name ____
   First Middle Last
2. Street ____
3. City ______________________ State _________ Zip _________________
4. Home Phone __________ Work Phone __________ Other ________________
5. Birthday ______________ Age ________ Birthplace ______________________
6. Social Security No. _____________ Driver's License No.____________________

B. Client's Marital Background:

1.Are you presently married? __If so, please answer the following questions.

2.Date of marriage ___________

3.Spouse's Name _________________ Spouse's Birthdate ______________________

4.Please furnish names, address and birthdate of all children born as a result of your present marriage.

Full Name	**Present Address**	**Birthdate**	**Age**

1. ____
2. ____
3. ____
4. ____
5. ____

C. Prior Marriages:

1. Have you been married before? ___If so, please answer the following.

Name of former Spouses	Date of Marriage	Date of Divorce or Death of Spouse

a. ____

b. ____

2. Were children born as the result of any previous marriage? _____ If so, furnish the names, address and birthdates of children born as the result of any previous marriage.

Full Name **Present Address** **Birthdate** **Age**

a. ____

b. ____

3. Are you presently paying or receiving support payments for children of a prior marriage? If so, please state amount.

Paying $ ______________________________per___________________________

Receiving $____________________________per___________________________

Client's Residence:

Please list addresses where you have resided for the past ten years, and the length of time at each residence.

Address From To

a. ____

b. ____

c. ____

d. ____

e. ____

D. Client's Work Background:

1. Are you presently employed? _____ If so, please indicate.
2. Name of present employer ____
3. Address of present employer ______________________________________
4. Present job title ____
5. Date started working for this employer ________________________________
6. Present salary $ _________________________________per_______________
7. How many hours per week are you employed? _________________________

E. Past Employment:

1. If you are not now working, have you in the past worked outside the home? If so, please list your employments for the past 5 years.

Name of Employer Address Dates of Employment Nature of work

1. ____
2. ____
3. ____

F. Spouse's Employment:

1. Is your spouse presently employed? _____ If so, please furnish the following.
2. Name of Employer ____
3. Address of Employer ____
4. Present job title and duties ____
5. Date spouse began working for this Employer _________________________
6. Number of hours per week spouse is employed ________________________
7. If your spouse is not presently working, has your spouse been employed n the past 5 years? ______ If so, please furnish the following:

Name of Employer   Address   Dates of Employment   Nature of work
1. ____
2. ____
3. ____

G. Employment missed due to injury:

1. Have you missed work as a result of your injuries? ____ If so, please answer the following questions:
2. Name of employer at time of injury ___________________________________
3. Address of employer at time of injury ________________________________
4. Job title at time of injury ____
5. Number of hours or days missed due to injury _________________________
6. Amount of pay, at the time work was missed, per hour, week, month ______
7. Hours of normal employment per week at time of injury __________________
8. Total amount of gross wage loss due to inability to work $ _________________
9. Any additional employment benefits you have lost because you could not work due to your injury? ____

   ____

10. Any additional information regarding wage loss or employment benefits you have lost because you could not work due to your injury ________________

    ____

11. Have you changed employment because of the injury _____ If, so explain

    ____

12. Has the nature of your work changed since the date of accident if you have returned to wok or continued working? ____ If so, explain fully __________
____

H. Past Hospitalizations:

1. Were you ever hospitalized *BEFORE* this accident _____ If, so please complete the following:

Name of Hospital	Length of Hospitalization	Date	Reason for Hospitalization

a. ____
b. ____
c. ____
d. ____

I. Past Illnesses:

Have you ever had any long-lasting, chronic or serious illnesses BEFORE this accident?____ If so, please complete the following:

Nature of Illness	Date	Name of Doctor

a. ____
b. ____
c. ____

J. Past Accidents, Broken Bones or Injuries:

Have you *BEFORE* the injuries in this case, had any broken bones, accidents of any kind, or injuries for any reason which required medical attention? ____ If so, please furnish the following information:

Nature of Accident	Injury	Date	Name of Doctor

a. ____
b. ____
c. ____
d. ____
e. ____

K. Past Medical Information:

1. Over the past five years, who has been your regular family doctor you have consulted when you have needed medical attention? If more than one

doctor, osteopath, chiropractor, or other physician has been used by you, please indicate below.

Name of Physician or Doctor | Date Seen | Reason Seen

a. ____

b. ____

c. ____

2. Have you had any prolonged or chronic health problems during your lifetime other than from the accident in this case? ____ If so, please describe fully:

____

____

3. Have you used any drugs or medication regularly *BEFORE* the accident in this case?___ If so, please describe the drug or medication and the purpose.

____

____

4. Have you ever had any auto, life, or health insurance declined or cancelled? If so, give that date and reason.

____

____

L. Military Background:

1. Have you ever been in the military? ______ If so, give dates ______________
2. Type of discharge received ____
3. Are you now receiving or have you ever received any payments for the Veterans Administration, Social Security, or other sources? If so, please give details.

____

____

4. What is your Veterans Administration number? ________________________

M. Police Record:

Other than minor traffic offenses, have you ever been convicted of a crime? If so, please give the following:

Criminal Charge | Date | Place

a. ____

b. ____

c.____

2. Is there now or has there ever been a restriction on your driver's license? If so, please give details. ____
____

3. Have you ever received any traffic tickets? If so, please furnish the following information:

Nature of ticket | Date | What was done about it

a. ____
b. ____
c. ____

N. Claims and Court Cases:

1. Have you ever made any claim for Industrial Insurance or a work-related injury at any time? If so, please state as follows:
   a. Type of claim ____
   b. Employer ____
   c. Date ___________________________ Injury _______________________
   d. Amount received or outcome ________________________________

2. Have you filed any claim for Social Security benefits due to injury? If so, explain below:
   a. Date ____
   b. Claim Number, if any _____________________________________
   c. Money Received or outcome _________________________________

3. Have you ever received any veteran's pension or benefits? If so, please explain below:
   a. Date ___________________________ Claim Number_______________
   b. Amount ___________________ Reason __________________________

4. Have you made any claim at any time for benefits from any other source. If so, state as follows:

   Nature of Claim | Date | Result

   a. ____
   b. ____
   c. ____

O. Educational Background:

Please furnish us with your education background:

	Name	Location	No. Years Attended	Year Left	Graduated Yes or No	Degree
High School						
College-University						
Business School						
Tech Training						
Other						

P. Religious and Fraternal Background:

1. Please list the fraternal organizations to which you now belong:

   a. ____

   b. ____

2. Please list your religious affiliation at the present time. Please give us the name of your pastor, priest, or rabbi as well.

   ____

Q. Client's medical insurance:

1. Do you have any medical insurance policy, including an automobile medical benefits policy, medical insurance through your employment or a private medical policy, which might pay the bills as a result of your injuries in this case? If so, please furnish the following information:
2. Name of Insurance Company ______________________________________
3. Address of Insurance Company ____________________________________
4. Policy Number ____
5. Insurance Adjuster, if any ____

6.Have any of your bills been paid by any medical insurance company, welfare, or any person other than yourself? If so, please furnish the following information:

   a. Name of company paying bills ____________________________________

   b. Please list the bills paid and the amounts of the reverse side of this sheet.

   c. Have you made any claim for payment of your bills from your medical insurance company, welfare, or other sources? If so, please describe.

   ____

7. Do you have any other insurance of any kind which would provide payments of your medical bills for this accident? If so, please furnish the following information:
   a. Name of Company ____
   b. Address of Company ____
   c. Name of Agent ____
   d. Address of Agent ____

R. Client's Auto Insurance:

1. Does your case involve an automobile accident? If so, please furnish the following information:
2. Name of auto insurance company __________________________________
3. Policy No. ___________________ Insurance Adjustor _________________
4. Did your policy have a provision for collision coverage? ________ If so, what was the deductible amount you have to pay for damage to your car? _____
5. Does your policy have a provision for paying medical bills? ______ If so, have you made a claim for your bills under your own insurance policy?____
6. Does you policy provide coverage if you are involved in an automobile accident with someone who does not have insurance? ______
7. Do you have a copy of your policy? ________ Insurance Agent?_________

S. Defendant's Insurance:

1. Did the defendant have insurance to your knowledge? _________________
2. If so, name of the insurance company ______________________________
3. Have you been contacted by the Defendant's insurance company? _____ If so, when _________________
4. Name of the Adjustor ______________
5. Do you know the amount of insurance the Defendant has? _____ If so, what is it? ____

T. Facts About Defendant:

1. Name _________________________________ Phone ________________
2. Street Address ____
3. City _________________________ State ______________ Zip _________
4. Name of Defendant's Spouse _________________ Employer ___________

U. Fact of the Accident:

1. Date _______________ Day ______________ Time ____________

2. Location of the Accident ____

3. If this an automobile accident case, please state as follows:

   a. Location of Plaintiff's vehicle at the present time ______________________

   b. Has vehicle been repaired? __________

   c. Have photographs been taken of the damage? _________________

   d. Location of Defendant's vehicle at the present time __________________

   e. Has Defendant's vehicle been repaired? _______________

   f. Have photographs been taken of the damage? ______________

4. Please describe exactly how the accident happened, giving as much detail as you can.

In the space provided below, please draw an illustration or diagram of the location of the accident and how it happened.

5. Is there anything that you feel is important about how this accident happened, or about the accident that you have not mentioned before? If so, please provide this information.

V. Police Investigation:

1. Was this accident investigated by any law enforcement officer ______ If so, by whom? ___City Police ___State Patrol ___ Sheriff ___ No one

2. State the name and address of the law enforcement officer who investigated. ____

3. Did you sign any written statement for any law enforcement officer who might have investigated this accident? ___ When? _______ Do you have a copy? ______ What did you tell them? __________________________

4. Did you sign anything? ______ What? ____________________________

W. Insurance Investigation:

1. Have you talked to any insurance adjustor about this accident? ________If so, please furnish the following information:

2. Name of Insurance Adjustor ____________________________________

3. Name of Insurance Company ____________________________________

4. Do you have his card? __________ If so, please attached it to this form.

5. Who was present at the time? ____________________________________

6. Did you sign anything? _________ What did you sign ________________

7. Did you get a copy? ____________What did you tell them? ___________

8. Did you talk with the insurance adjustor on the phone? _______________

9. Did he make a recording of what was said? ________ If so, do you have a copy?

X. Evidence:

1. Do you know of anyone who would have any photographs showing:

   _________ your injuries

   _________ damage to the car

   _________ location of the accident

   _________ or any other photographs about this case

2. Do you know of any diagrams or drawings which were made in connection with this accident? If so, please describe fully. ______________________

3. Do you know of any other evidence we might obtain regarding this accident? ____

Y. Witnesses:

1. At the time of the accident, were you with anyone else? ____ If so, please list their names and addresses and where they were at the time of this accident.

   Name Address Where Located

a. ____

b. ____

c. ____

2. Do you know of any witnesses who actually saw the accident happen? If so, please give the following information.

Name Address Phone

a. ____

b. ____

c. ____

3. Do you know of any witnesses who arrived after the accident or know something about the accident but did not actually see it happen? If so, please give the following information (if you need more room, please use reverse side).

Name ____

Address ____

Phone ________________________ Age ______ Job ________________________

What do they know ____

Name ____

Address ____

Phone ________________________ Age ______ Job ________________________

What do they know ____

4. Please furnish the names of anyone who may know about your injuries. This would include members of your family, neighbors, friends, anyone who may know about your injuries or how they have affected you or what effect they may have had on your hobbies, activities, or physical condition in general.

Name ____

Address ____

Phone ________________________ Age ______ Job ________________________

What do they know ____

Name ____

Address ____

Phone _______________________ Age ______ Job _______________________

What do they know ____

Name ____

Address ____

Phone _______________________ Age ______ Job _______________________

What do they know ____

Z. Statements by other party:

1. Did the Defendant admit being at fault at any time? If so, please explain fully: ____

   ____

2. Do you know of anything else that the Defendant might have said about this accident? If so, describe fully. ____

   ____

AA. Hospital care as a result of injuries:

1. As a result of your injuries, were you in the hospital? If so, indicate as follows:

Name of Hospital	Length of Hospitalization	Reason for Hospitalization
a.		
b.		
c.		

BB. Medical or Chiropractic Care Received as a result or accident:

1. What doctors, osteopaths, chiropractors or physical therapists have you seen as a result of this accident?

a. ____

b. ____

c. ____

CC. Drugs and medication as a result of this accident:

1. As a result of the accident, have you taken any aspirin, drugs, medication or any other prescription on the advice of a doctor? If so, please furnish the following information:

   Drug or medication   Drug store where purchased   Dates Taken

   a. ____

   b. ____

   c. ____

   d. ____

DD. Other care received:

1. Have you had to have any special nurses or have any friends or others act as nurse in connection with this accident? If so, please furnish the following information:

   Name of person   Dates   Amount Paid, If any

   a. ____

   b. ____

   c. ____

2. Have you had to hire or obtain anyone around the house as a result of this accident, to help out? This would include babysitters, people to do washing, ironing, etc., anyone who may have been obtained to come into the home and help out because of the accident? If so, please furnish the following information.

   Name of person   Dates   Nature of work done

   a. ____

   b. ____

3. Have you used any of the following in connection with treatment?

   From   To

   Back or neck brace? ________ Dates: ___________________________________

   Crutches? _________________Dates: ___________________________________

   Traction? __________________Dates: ___________________________________

   Physiotherapy? _____________Dates: ___________________________________

Other? ____________________Dates: _____________________________________

EE. Injuries Received:

1. Describe in detail what injuries you received in this accident. If you received broken bones, describe these specifically. Please indicate here what injuries you received as a result of this accident in as great detail as you are able to.

____

____

____

____

2. If not fully covered above, what does your doctor say about the injuries you received in this accident?

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3. Describe in detail what has been done for you since the accident. Include the treatment you received at the hospital, what the doctor has prescribed for you, and what you do to take care of the injuries.

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FF. Out-of-pocket expenses:

We would like to have all of the bills that you have received because of this accident. Please attach them to this questionnaire. We would like you now to summarize the expenses incurred because of this accident, in detail.

1. Physicians and Surgeons:

Name	Address	Amount	Paid?

2. Hospitals:

Name	Address	Amount	Paid?

3. Ambulances:

Name	Address	Amount	Paid?

4. Special Nurses

Name	Address	Amount	Paid?

5. Domestic Help:

Name	Address	Amount	Paid?

6. Drugs-Medications:

Name of Drug	Name of Store	Amount	Paid?

7. Crutches, Braces, Traction, etc.

Name	Address	Amount	Paid?

8. X-Rays:

Name of Doctor	Address	Amount	Paid?

9. Auto Repair:

a. Name of company repairing ______________________________

b. Address ____

c. Amount of repair bill ____

10. Car Rental:

a. Name of company where car rented ___________________________________

b. Address ____

c. Amount of car rented ____

d. Date car rented ____

11. Wage Loss:

a. Dates work missed because of accident ___________________________

b. Amount per hour lost because of accident _________________________

c. Total amount of wage loss _____________________________________

d. Number of hours missed from work because of accident ______________

12. Other Expenses:

Nature of Expense	Amount	Paid?

13. Please summarize your out-of-pocket expenses on the following list:

	Amount	Paid
Physicians and Surgeons		
Hospitals		
Ambulances		
Nurses		
Drugs		
Crutches, braces, etc.		
X-Rays		

Auto Repair
Car Rental
Lost Wages
Other

GG. Effect of injuries:

1. *Before* this accident, what sort of activities did you enjoy doing after work or outside the home? Please indicate the nature of the activity, such as bowling, skiing, gardening, hunting, etc., in detail, and how often before the accident you would normally take part in such activities. Furnish as much information about this as you can.

Activity How Often

a. ____

b. ____

c. ____

d. ____

2. Exactly what effect has the accident had upon these activities? We would like you to describe in detail those hobbies and activities listed above which you have not been able to perform after the accident or can be performed only with difficulty. Please describe the exact effect of the accident upon your ability to perform these activities.

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3. With regard to your work around the home and your employment, if any, we would like to know what effect these injuries have had. We would like you to list the exact

nature of the activities, such as climbing the stairs, ironing, cutting grass, dancing, lifting children, etc., and the effect which the injuries have had upon it. With respect to any employment, we would like to know the exact work required, such as lifting boxes, driving truck, physical activity, etc., and the effect of the injuries upon such work activity. Please furnish exact details.

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4. Were you ever confined in bed at home as the result of this accident? If so, please give the dates when you were confined in bed and the reason.

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5. If you were attending school at the time of the accident and lost time from school, please furnish the dates you lost time from school and the reason.

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6. Were you at the time confined to your home after the accident, if not confined to bed? If so, please furnish the dates and the reasons for such confinement?

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7. Please describe in detail any pain which you have experienced because of the accident, and the frequency and nature of it.

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8. If not previously listed, have you experienced any other difficulties of any kind because of this accident? If so, please describe in detail.

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9. Please describe how you are getting along and how you feel at the present time.

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HH. Miscellaneous:

1. Do you have or are you aware of any photographs which were taken pertaining to this accident? If you have them, please attach them to this questionnaire.
2. Have you received any awards or special recognition of any kind during your lifetime? If so, please describe the same.

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II. Conclusion:

1. Can you think of anything that you have not told us about that may have some bearing upon your case? If so, please indicate that on the following lines.

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2. In completing this interview outline, have you thought of any information which we may not have asked you about and which may be of some assistance to us in connection with your accident claim? If so please indicate this on the following lines.

____

Dated this ______________day of 20___

I HAVE READ THE ABOVE STATEMENT AND THE SAME IS TRUE AND CORRECT

____

Client