LAW OFFICES OF

SCOTT BOWEN

A PROFESSIONAL LIMITED LIABILITY COMPANY

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PERSONAL INJURY QUESTIONNAIRE

(Please Print)

Name ______________________________ Date ____________________

Address ____
(street) (city) (state) (zip code)

Phone No. (home) ______________ (work) ________________ (cell) ________________

Email Address ____

Which form of communication is the best to reach you on? ☐ Home ☐ Work ☐ Cell ☐ Email

Date of Birth __________________ SSN ______________________________

Marital Status M D S W Spouse Name ______________________________

Description of Injury ____

Please Check the Box(s) that Pertain to Your Injuries:

Loss of Consciousness ☐ Soft Tissue ☐ Bruising ☐ Scarring ☐
Head Injury ☐ Radiating Pain ☐ Lacerations ☐
Headaches ☐ Disc Injury ☐ Broken Bones ☐

Treatment Since Accident:

Ambulance ☐ Medical Doctor ☐ Physical Therapy ☐ Surgery ☐
Emergency Room ☐ Naturopath ☐ Massage Therapy ☐ Future Surgery ☐
Hospital Admission ☐ Chiropractor ☐ Acupuncture ☐

Prior Accident(s): Date(s) ____

Prior L&I claim(s): Date(s) ____

Other Medical History ____

Family Doctor: ____

Address and Phone Number: ________________________ Clinic Name: ______________

Interests/Hobbies ____

Education ____

Children (s) Name\ages ____

Driver's License Number ___________________________

Accident Information

Who can we thank for your referral? ____

Date of Injury ____________   Time of Day __________ a.m.   p.m.

Location of Accident: (Name of street, road or highway) ______________________________

(Intersection) ____

(County) ________________ (City) ____

(Other) ____

Direction: ☐ North ☐ South ☐ East ☐ West

Police Investigated: ☐ State Patrol ☐ County ☐ City ☐ No Investigation ☐ Other

Case Number __________________ Officer's Name __________________________________

Were citations issued? ☐ Yes ☐ No

If so, to Who and What Violation____

Were you the:
Driver ☐ Passenger ☐ Pedestrian ☐ Motorcyclist ☐ Bicyclist ☐
Wearing Seatbelt ☐ Airbag Deployed ☐

No. of vehicle's involved:______

No. of people in your vehicle:______ Your Speed:______

No. of people in other vehicle:______ Other speed:______

Describe Accident ____

____

____

____

Had you consumed any Alcohol/ Drugs/ Medication 24hrs prior to the accident: ☐ Yes ☐ No
If yes, what and how much? ____

Defendant / Insurance Information

Name of Defendant ____

Address ____
(street) (city) (state) (zip code)

Insurance Carrier ______________________ Policy / Claim No.__________

Name of Insurance Adjuster ____

Address ____
(street) (city) (state) (zip code)

Phone ______________________________

Acting Within Scope of Employment: ☐ Yes ☐ No Company Name ______________

Your Insurance Information

Auto Insurance Carrier ______________________ Policy No. ______________

LIABILITY ________ UM/UIM ________ PIP _________

Policy Holder Name (if different than self) ______________________________

Name of Insurance Adjuster ____________________ Claim No. ______________

Address ____
(street) (city) (state) (zip code)

Phone No.______________________________

Medical Insurance ______________________ Plan No. ______________

Address ______________________ Phone No. ______________
(street) (city) (state) (zip code)

DSHS - ☐ Yes ☐ No

Acting Within Scope of Employment: ☐ Yes ☐ No L&I Claim No.: ____________

Witness Information

Name of Witness ______________________ Phone ______________

Address ____
(street) (city) (state) (zip code)

Employment Info.

Current Employer ____

Address ____
(street) (city) (state) (zip code)

Phone No. ____________________ Supervisor's Name ____________________

Title of Your Position ______________ Salary $________ /year $_______/month

Description of Duties ____

Has accident caused you to lose time from work? ☐ Yes ☐ No

Employer at time of accident, if different from above ________________________

Address ____
(street) (city) (state) (zip code)

Employer's Phone No. ______________ Supervisor's Name ____________________

Title of Your Position ______________ Salary $________/year $_______/month

Description of Duties ____

Has accident caused you to lose time from work? ☐ Yes ☐ No

Property Damage Information

Is Property Damage an Issue? ☐ Yes ☐ No

If so, has your Property Damage been Resolved: ☐ Yes ☐ No

If so, by who? ____

Your vehicle description: Make\Model ______________________________________
Your property damage amount: $ ________________
Was your vehicle towed? ☐ Yes ☐ No If so, by who? ________________________

Others vehicle description: Make\Model ______________________________________
Their property damage amount: $ ________________
Was their vehicle towed? ☐ Yes ☐ No If so, by who? ________________________

Treatment Resulting From Current Accident

Ambulance ______________________________ Phone ______________________________

Address ____
(street) (city) (state) (zip code)

Hospital ______________________________ Phone ______________________________

Address ____
(street) (city) (state) (zip code)

Doctor's Name ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Current Treatment Frequency____
(Visits per week / month) (Next Follow-up Exam)

Doctor's Name ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Current Treatment Frequency____
(Visits per week / month) (Next Follow-up Exam)

Doctor's Name ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Current Treatment Frequency____
(Visits per week / month) (Next Follow-up Exam)

Doctor's Name ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Current Treatment Frequency____
(Visits per week / month) (Next Follow-up Exam)

Doctor's Name ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Current Treatment Frequency____
(Visits per week / month) (Next Follow-up Exam)

Pharmacy ______________________________ Phone No. ______________________________

Address ____
(street) (city) (state) (zip code)

Other Out of Pocket Expenses ____
____

Please add in the space below any additional information or comments relative to your accident which you feel will help us in obtaining a satisfactory settlement for you. For example, consider any statements made by the defendant or yourself, remarks of the police investigating the accident, and how the accident has affected your lifestyle, job responsibilities, and /or family life.

____
Signature

____
Space Below For Office Use Only