3724 Lake Washington Blvd NE, Kirkland, WA 98033 | 425.284.6000 | Fax 425.284.6001 | www.lingenbrink.com

PERSONAL INJURY QUESTIONNAIRE

(Please Print)

Name ____ Date ___________________________

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

Phone No. (home) _______________ (work) ___________________ (cell) ____________________

Email Address _______________________________________ Mobile Carrier _______________

Facebook/Website_______________________________________ Text OK? Y / N

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 ____

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
MEDICARE - ☐ 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 whom? ____________________

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

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 ____
____

Bankruptcy

Have you ever filed or do you plan to file bankruptcy?______________________________

Name of bankruptcy attorney____

Street address____

Telephone Number____

Emil Address____

Date Filed:____

Date Discharged: ____

Case Number:____

Court Where Filed:____

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