



LINGENBRINK
L A W

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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