

**MEDICAL MALPRACTICE  
CLIENT INTAKE QUESTIONNAIRE**

**Date of INCIDENT:** \_\_\_\_\_ **Date aware of any WRONGDOING:** \_\_\_\_\_

**A. CLIENT INFORMATION**

1. Name: \_\_\_\_\_  
\_\_\_\_\_

*If this is a wrongful death claim, list your name, decedent's name, & your relationship to decedent*

*Decedent's Name:* \_\_\_\_\_

*Relationship:* \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Previous Address #1: \_\_\_\_\_

Year(s): \_\_\_\_\_

Previous Address #2: \_\_\_\_\_

Year(s): \_\_\_\_\_

Previous Address #3: \_\_\_\_\_

Year(s): \_\_\_\_\_

Previous Address #4: \_\_\_\_\_

Year(s): \_\_\_\_\_

3. Who do you live with (list all): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Message Phone: \_\_\_\_\_

5. Primary Email Address: \_\_\_\_\_

6. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female

7. Social Security #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_

8. Driver's License #: \_\_\_\_\_ Expires: \_\_\_\_\_ State: \_\_\_\_\_

9. If no Driver's License, State ID #: \_\_\_\_\_ Expires: \_\_\_\_\_ State: \_\_\_\_\_

10. Employer Name: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_
11. Address: \_\_\_\_\_
12. Contact Person / Title: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Relationship: \_\_\_\_\_
13. If client is a minor or living at home, parent's names and employers:  
 Name of Mother: \_\_\_\_\_  
 Name of Father: \_\_\_\_\_  
 Mother's Employer & Telephone #: \_\_\_\_\_  
 Father's Employer & Telephone #: \_\_\_\_\_
14. Client's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Other: \_\_\_\_\_  
 If married on date of loss, name of spouse:  
 \_\_\_\_\_
15. If client has children:  
 Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
16. Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Did you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ Date Quit: \_\_\_\_\_
17. How did you hear about our office? Web Page \_\_\_\_\_ Friend \_\_\_\_\_ Other \_\_\_\_\_  
 Doctor (name): \_\_\_\_\_  
 Referred by attorney (name): \_\_\_\_\_







Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

2. Name of your **SECONDARY** medical insurance company:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

3. **MEDICARE** Advantage Company:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

4. **MEDICAID:**

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

**D. MEDICAL TREATMENT**

1. Ambulance. Were you taken to the hospital by ambulance? Yes \_\_\_\_ No \_\_\_\_ If Yes,

Date \_\_\_\_\_

Name of Ambulance Company:

\_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Hospital Care. Indicate the date, name of hospital or facility, dates of stay, and reason for hospitalization.

Date	Name & Location of Facility	Dates of Stay	Reason

3. Doctors and Health Care Professionals - Previous. List each doctor and health care professional who has treated you the **PREVIOUS 5 YEARS BEFORE** the incident.

Date	Name of Provider	Telephone #	Reason for Visit

4. Doctors and Health Care Professionals - Current. List each doctor and health care professional who has treated you **AFTER THE INCIDENT.**

Date	Name of Provider	Address	Reason for Visit

**E. EMPLOYMENT/WAGE LOSS**

1. Name, address, and telephone number of employer or personnel department at the time of the incident:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Length of employment: \_\_\_\_\_

3. Income: \_\_\_\_\_ Per: hour \_\_\_ day \_\_\_ week \_\_\_ month \_\_\_ other: \_\_\_\_\_

4. Hours you normally work per day: \_\_\_\_\_ per month: \_\_\_\_\_

5. Have you returned to work since this incident? Yes \_\_\_ No \_\_\_ , If no, list dates and number of hours of work missed:

\_\_\_\_\_

\_\_\_\_\_

---

---

6. Total amount of income lost to date due to injuries: \_\_\_\_\_

7. Brief description of your job duties:

---

---

---

8. If working, has your employer placed you on light duty or accommodated you in another way?

Yes \_\_\_ No \_\_\_

If Yes, please explain:

---

---

---

**F. OUT-OF-POCKET EXPENSES**

1. List any out-of-pocket expenses relating to this incident.

Paid To	Paid By	Date Paid	Description	Amount	Receipt Y or N

**G. PAST ACCIDENTS /INJURIES**

1. Prior to this incident, have you had an accident or injuries to the affected body part which required medical attention?

Yes \_\_\_\_ No \_\_\_\_ If Yes, please provide the date, and the name of the provider, and nature of the injury.

<b>Date</b>	<b>Name of Provider</b>	<b>Nature of Injury</b>

2. Prior to this incident, were you ever hospitalized for the condition or body part involved in your claim?

Yes \_\_\_\_ No \_\_\_\_ If Yes, please state the date, name of each hospital, reason for hospitalization, and length of stay:

<b>Date</b>	<b>Name of Hospital</b>	<b>Reason for Hospitalization</b>	<b>Length of Stay</b>

**H. CLAIMS AND COURT CASES**

1. Have you ever made a claim for a work-related injury at any time, including *Workers Compensation or Industrial Insurance*?

Yes \_\_\_\_ No \_\_\_\_ If Yes, please list for each claim:

a) Type of claim: \_\_\_\_\_ Date: \_\_\_\_\_ Reason:

---

---

Employer:

---

Amount received or outcome:

---

---

b) Type of claim: \_\_\_\_\_ Date: \_\_\_\_\_

Reason: \_\_\_\_\_

---

Employer:

---

Amount received or outcome:

---

2. Have you filed any claim for *Social Security benefits* due to injury? 9 Yes 9 No

If Yes, please provide the following information:

Date: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Reason:

---

Amount received or outcome:

---

---

3. Have you ever received *Medicare or Medicaid benefits*? Yes \_\_\_\_ No \_\_\_\_ If Yes, please provide the following:

ID No. \_\_\_\_\_

Contact Information:

\_\_\_\_\_

4. Have you ever received any *veteran's pension or benefits*? Yes \_\_\_\_ No \_\_\_\_ If Yes, please provide the following information: Date: \_\_\_\_\_ Claim No.:

\_\_\_\_\_ Reason: \_\_\_\_\_

Amount received or outcome:

\_\_\_\_\_

5. Have you ever made any claims at any time for *benefits from other sources*?

Yes \_\_\_\_ No \_\_\_\_ If Yes, please provide the following information:

Date: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Reason: \_\_\_\_\_

Amount received or outcome:

\_\_\_\_\_

6. Have you ever been charged with or convicted of a criminal offense?

Misdemeanor: Yes \_\_\_\_ No \_\_\_\_ Felony: Yes \_\_\_\_ No \_\_\_\_

If yes, provide the following information:

(a) Charge: \_\_\_\_\_

Date: \_\_\_\_\_

Location: \_\_\_\_\_ Disposition: \_\_\_\_\_

(b) Charge: \_\_\_\_\_

Date: \_\_\_\_\_

Location: \_\_\_\_\_ Disposition: \_\_\_\_\_

(c) Charge: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Location: \_\_\_\_\_ Disposition: \_\_\_\_\_

7. Have you ever filed a lawsuit in any court? Yes \_\_\_\_ No \_\_\_\_ If so, please state for *each* case the date, name, and location of court where filed, title of case & case number, nature of case, and final outcome:

---



---



---



---

**I. EDUCATIONAL BACKGROUND.** Please provide the name, location, number of years attended, date completed, whether or not you graduated, and degree(s).

	Name	Location	Years Attended	Date Completed	Did you Graduate? Y or N	Degree
High School						
College or University						
Business School						
Technical Training						
Other						

**J. INCOME TAX RETURNS**

1. Have you filed tax returns for the five years previous to your current medical condition?

If yes, please list years filed: \_\_\_\_\_

If yes, do you have them in your possession? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, do we have permission to obtain your tax transcripts online from the IRS: \_\_\_\_\_

**K. OTHER**

1. **WRITINGS.** Do you have any writings of any kind, including, but not limited to: notes, calendars, diaries, journals, emails, text messages, blogs, social-network or other online postings, Facebook pages, electronically stored information, or any other documents or electronic media, which include entries by you or your family members related to your medical condition or the medical care and treatment at issue?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

\_\_\_\_\_

2. **SOCIAL NETWORKING.** Do you have any social networking accounts, such as Facebook, LinkedIn, MySpace, or do you operate or participate in a blog, microblog (e.g., Twitter), photoblog, chat-room, message board, personal websites, etc?

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please list, providing URLs (web links), if possible:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

6) \_\_\_\_\_

3. **CELL PHONE.** Who is your cell phone provider: \_\_\_\_\_

Do you send and receive text messages: Yes \_\_\_\_\_ No \_\_\_\_\_

4. Have you ever been quoted or profiled by any newspaper, magazine, website, or other entity or person that is likely to have an online presence? If so, please describe, providing URLs (web links), if possible.

---

---

---

---

3. **EMAIL.** Do you have more than one email account? Yes \_\_\_\_ No \_\_\_\_

If Yes, please list:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

4. **ALIASES.** What are your various online aliases (e.g., for comment boards, Gaming, etc.)

- 1) \_\_\_\_\_ For: \_\_\_\_\_
- 2) \_\_\_\_\_ For: \_\_\_\_\_
- 3) \_\_\_\_\_ For: \_\_\_\_\_

5. **PHOTOS.** Do you have any photographs, videos, charts, drawings, diagrams, or other representations which in any way pertain to your current medical condition? Yes \_\_\_\_ No \_\_\_\_

If Yes, please describe:

---

---

---

---

