GWC Law Firm

Confidential Client Information Sheet

How did you hear about us? phone book / web site / TV ad / referral:_____

Name
Address
City, St, Zip
Home Phone
Cell Phone
Work Phone
Email
If you are here on behalf of someone else, their Name

I am interested in (check all that apply):

Family Law	**Estate Planning**	**Business/Civil**	**Criminal**
☐ Divorce/Annulment	☐ Wills & Trusts	☐ Business	☐ Misdemeanor
☐ Child Custody/Support	☐ Living Will	☐ Taxation	☐ Felony
☐ Name Change	☐ Power of Attorney	☐ Personal Injury	☐ Juvenile
☐ Adoption	☐ Healthcare PoA	☐ General Civil Litigation	☐ Class C Citation
☐ Pre-Marital Counsel	☐ Elder Care Planning	☐ Debt Relief/Bankruptcy	☐ Traffic Ticket

Please give a brief description of your legal problem:

_____

_____

_____

_____

_____

WAIVER & CONSENT

I certify that I am not currently represented by an attorney with regard to the matter I am here for today, or if I am represented, I am here for a second opinion. I understand that all matters discussed with the attorney are subject to confidentiality under the attorney-client privilege. The attorney may not discuss the matters with third parties without my consent except as needed to carry out representation of me. The law also requires the attorney to disclose my confidential information if: ordered by the court, the Texas Disciplinary Rules, other law, to defend against civil or criminal charge, to prevent the client from committing fraud or criminal act, or to rectify fraud or criminal acts.

I further certify that I will be truthful with the attorney with regard to potential conflicts of interest and all other matters. I realize it is in my best interest to be honest with the attorney so that I get the best legal advice. The fee for today's visit is $_____

Date:_____ Sign:_____

GWC PERSONAL INJURY/AUTO ACCIDENT
INTAKE SHEET

INITIAL CLIENT STATEMENT

HAVE YOU SPOKEN TO ANOTHER ATTORNEY ABOUT THIS CASE?_____

IF SO, PLEASE GIVE NAME OF ATTORNEY: _____

DO YOU HAVE A SIGNED RELEASE BY THAT ATTORNEY? _____

WHO WERE YOU REFERRED BY: (INDIVIDUAL, YELLOW PAGE AD, ETC.)

_____

PERSONAL INFORMATION:

NAME: _____

Address: _____

Telephone Number: (home) _____

Age: ___ Date of Birth: _____ Social Security No: _____

EMPLOYER: _____

Address: _____

Telephone Number: (work)_____

Occupation: _____ Worked there how long?_____

Immediate Supervisor: _____

SPOUSE'S NAME: _____

Address: _____

Telephone Number: (home) _____

Spouse's Employer: _____

Employer's Address: _____

Telephone Number: (work)_____ Occupation: _____

Age: ___ Date of Birth: _____ Social Security No: _____

CHILDREN:

Name(s)/Age(s): _____

_____

_____

How many children are living with you now? _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

EDUCATION:

High School/G.E.D.: _____ Year of Graduation: _____

Technical School: _____

College/University: _____Years & Degree: _____

EMPLOYMENT HISTORY:

Employer: _____ Position: _____

Duties: _____

_____

Employer: _____ Position: _____

Duties: _____

_____

Employer: _____ Position: _____

Duties: _____

_____

Employer: _____ Position: _____

Duties: _____

_____

Prior **similar injuries**, treated medical conditions and/or symptoms

to same area or current injury (Dates/Drs.): _____

_____

_____

_____

_____

Prior **claims and/or settlements** (types, dates, attorneys):

_____

_____

List any **prior injury settlements**: _____

_____

_____

ACCIDENT INFORMATION:

Accident Date: _____ Date of Week: _____

Time: _____ am/pm

Location: (Be Specific)_____

_____

Where were you coming from? _____

Where were you going? _____

DETAILS OF ACCIDENT:

Weather condition (if happened outside): _____

Any construction in the area? _____

DESCRIPTION OF ACCIDENT: (BE SPECIFIC-- GET AS MUCH DETAIL AS POSSIBLE)

_____

_____

_____

(Description of accident continued)

Did this injury occur when you were driving a vehicle?

Were you driving a company vehicle?

What was the make, model and year of the vehicle you were driving?

What was the make, model and year of the other vehicle?

Was anyone, including yourself, to the best of your knowledge, taking any medication or using any sort of drugs?

Had anyone, including yourself, been drinking?

Did anyone make a statement at the scene?

Who made such a statement, if any?

What was said?

_____

To whom?_____

Were photographs taken of the scene?_____

INSURANCE COVERAGE FOR PLAINTIFF:

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

_____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

Cash Policy for Accidents: _____

Effective Dates of coverage: _____

Is this a WORKER'S COMP CLAIM? _____

Are you covered through your employer's insurance? _____

If so, provide company and agent, if known: _____

Policy or plan number: _____

Name of insured: _____

Limits of coverage: _____

Did you file a claim with your insurance company? _____

Has anyone from the insurance company contacted you about this claim? _____

Name of Person who contacted you: _____

When was contact made? _____

If a statement was given, was it tape recorded or written?

_____

Did you receive a copy? _____

Have you signed any authorizations to release information to anyone? _____

If so, identify: _____

Have you signed any releases? _____

If so, for whom? _____

Have you received any insurance benefits? _____

Have you been judged by any administrative agency as partially or permanently disabled as a result of this injury? _____

If so, which agency? _____

INSURANCE COVERAGE FOR DEFENDANT:

Name of Carrier: _____

Carrier's Address: _____

Policy Number: _____

Agent's Name, Address and Phone No.: _____

_____

Collision coverage amount: _____

Deductible Amount: _____

Liability Coverage: _____

Medical Payment Amount: _____

Uninsured Motorist Coverage Amount: _____

MEDICAL INFORMATION:

Were you injured in this accident? ___ Describe: _____

_____

_____

_____

Did you go to the hospital? _____

Which hospital _____

Admitted or Out Patient? _____

If admitted, release date: _____

X-Rays taken? _____ Were you taken by ambulance? _____

Are you under the care of a physician now? _____

LIST DOCTORS:

1. Name: _____ Phone: _____

   Address: _____

   _____

   Telephone Number: _____

   When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

2. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

3. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

4. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

5. Name: _____ Phone: _____

Address: _____

_____

Telephone Number: _____

When did you last see the doctor? _____

When will you see the doctor again? _____

Physical therapy? _____

Current Balance on Medical Bills: _____

PRESCRIPTIONS: BRING IN ALL RECEIPTS, BILLS, ETC. NOTE USE OF CERVICAL COLLAR, CASTS, WALKER, CRUTCHES, ETC. HAVE CLIENT BRING IN FOR EVIDENCE WHEN FINISHED USING, OR WHEN CAST IS REMOVED.

Was anyone else injured? _____

Who was injured? _____

Describe Injury: _____

_____

NAME AND ADDRESS OF ALL PARTIES INVOLVED, INCLUDING AUTO PASSENGERS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

WITNESSES:

1. NAME & ADDRESS: _____

_____

_____

Telephone Number: (___)_____

Relationship (fellow employees, supervisors, bystanders, etc.):

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

2. NAME & ADDRESS :_____

_____

_____

Telephone Number: (___)_____

Relationship (fellow employees, supervisors, bystanders, etc.):

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

3. NAME & ADDRESS: _____

_____

_____

Telephone Number: (___)_____

Relationship (fellow employees, supervisors, bystanders, etc.):

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

4. NAME & ADDRESS: _____

_____

_____

Telephone Number: (___)_____

Relationship (fellow employees, supervisors, bystanders, etc.):

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

5. NAME & ADDRESS: _____

_____

_____

Telephone Number: (___)_____

Relationship (fellow employees, supervisors, bystanders, etc.):

_____

What did each see? _____

Would they be willing to testify in court to what he/she saw? _____

VIEWING THE SCENE:

Can we go to the accident scene? _____

Is the equipment available for inspection? _____

Who do we contact to arrange a viewing? _____

NAME & ADDRESS: _____

Telephone Number: (___)_____

Job Title: _____

Can we photograph the equipment? _____

Any other information you feel may assist us in representing you for this claim? _____

DIAGRAM OF HOW ACCIDENT OCCURRED:

DAMAGES:

How have your injuries changed your lifestyle:

Loss of consortium (relationship with spouse, children, others): _____

_____

Sports: _____

_____

Social Activities: _____

_____

_____

Job Duties: _____

_____

Household Chores: _____

_____

Have you had to hire domestic help? _____

How do you feel you have been damaged emotionally by these injuries? _____

_____

_____

How do you feel you have been damaged financially by these injuries? _____

_____

_____

_____