SELARZ LAW CORP.

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Client Intake Questionnaire

1) **Name**: [Client's Name] **Date of Birth**: ____________________

2) **Contact Information**:

   Address: ____________________

   Phone No.: ____________________ Email: ____________________

3) **Alternate Contact Persons** (*Please list two*):

   Name: ____________ Relationship: ____________ Phone No.: ____________

   Name: ____________ Relationship: ____________ Phone No.: ____________

4) **Social Security Number**: ____________________

5) **Marital Status**: ☐ Single ☐ Married Spouse's Name ____________

6) **Country of Legal Residence**: ☐ United States ☐ Other: ____________

7) **Date of Accident**: ____________________

8) **Type of Case**: ☐ Motor Vehicle ☐ Slip-and-Fall ☐ Dog Bite
   ☐ Product Defect ☐ Other: ____________

9) **At-Fault Party's Information** (*Name, address, phone number, license, etc.*): ____________

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10) **Facts of Case** (*Please give as much detail as possible about what happened*): ____________

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11) **Was a Police Report taken**? ☐ Yes ☐ No

12) **Insurance Information**:

   Your Automobile Insurance Provider: ____________________

   Policy No.: ____________________ Claim No.: ____________________

   Your Health Insurance Provider: ____________________

   Policy No.: ____________ Primary Policy Holder: ____________

   ☐ Medicare No.: ____________ ☐ Medi-Cal No.: ____________

13) **Other Party's Insurance Information** (*If known*):

Defendant's Insurance Provider: ______________________________

Policy No.: ____________________ Claim No.: ____________________

Name of Adjuster: ____________________ Phone No.: ____________________

14) **Property Damage** (*Description of damage and if/where it is being repaired*): ____________

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15) **Physical Injuries** (*Description of injuries*): ______________________________

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16) **Have you received medical treatment**? ☐ Yes ☐ No

17) **Health Care Providers** (*Please use additional paper if necessary*):

Facility Name: ______________________________

Address: ____________________ Phone No.: ____________________

Facility Name: ______________________________

Address: ____________________ Phone No.: ____________________

Facility Name: ______________________________

Address: ____________________ Phone No.: ____________________

18) **Did you miss work because of your accident**? ☐ Yes ☐ No

Employer: ____________________ Phone No.: ____________________

19) **Witness Information** (*Please use additional paper if necessary*):

Name: ____________________ Phone No.: ____________________

Name:____________________ Phone No.: ____________________

Name: ____________________ Phone No.: ____________________

20) **Prior Accidents/Workers' Compensation Claims**:

Date: ______________ Injuries: ______________________________

Date: ______________ Injuries: ______________________________

Date: ______________ Injuries: ______________________________

21) **Who referred you to us**? ______________________________

22) **Additional Information**: ______________________________

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