Physical Address:
1931 TWENTY-THIRD AVENUE
MERIDIAN, MISSISSIPPI 39302-5022
TELEPHONE 601-693-5400

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JOSEPH A. DENSON
Admitted in Mississippi and Alabama, and
U.S. District Court of Illinois-Rock Island Division

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION

Name:______________________________Date:______________

Please list all other names by which you have ever been known, including marital and maiden names, nicknames, and aliases:____

Home Address:____
Prior addresses in the past 3 years (please indicate period of time and dates for each):
____

Home Phone:______________ Cell Phone:______________ Work Phone:____________

Social Security Number:_________________

Contact Preference : Home Phone: __ Cell Phone:__ Work Phone:__ Other:___________

E-mail Address:___________________________________

Date of Birth:________________ Place of Birth (City & State):____________________

Are you married? Yes__ No__

If yes, Date of Marriage:__________ Place of Marriage:___________________________

Spouse's Name:____

Spouse's Cell Phone:___________________ Spouse's Work Phone:_________________

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Injury or Accident

Date of Incident:_____________ Location of Incident:________________________________

Names. Addresses, and Telephone Number's (if known) of other people involved:

____

____

____

____

State all injuries known to be a result of the accident:

____

____

____

____

Length of time confined to bed:_____________ Length of time confined to house:_______

Please state present physical conditions, including scars, disabilities, deformities and discomforts due to the injuries.____

____

____

Health Insurance Provider:____

Auto Insurance Provider:____

Videos/Photos of Accident or injuries: [yes] or [no]

Estimated Total Doctor Bills:$________________________(to date)

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Physicians, Doctors, Surgeons, Chiropractors, Physical Therapist, Orthopedic Surgeons, Physical Surgeons

Please list all physicians and surgeons you have seen for this injury (attach additional page if necessary).

1. Name: ____
   Address:
____
   Nature of treatment: Diagnosis:____
   Nature of treatment:
Treatment:____
   Nature of treatment: DII:____
   Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.
____

____

2. Name: ____
   Address:
____
   Nature of treatment: Diagnosis:____
   Nature of treatment:
Treatment:____
   Nature of treatment: DII:____
   Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.
____

____

3. Name: ____
   Address:
____
   Nature of treatment: Diagnosis:____
   Nature of treatment:
Treatment:____
   Nature of treatment: DII:____
   Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.
____

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

4. Name: ____
Address: ____
Nature of treatment: Diagnosis:______________________________
Nature of treatment:
Treatment:________________________________
Nature of treatment: DII:______________________________
Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.

Nurses, Therapists and Health Care Professionals(Clinic/ Chiropractic Name)

List all nurses, therapists, and health care professionals other than doctors and surgeons that you have seen (attach additional page if necessary).

Name:_____________________ Address:_________________________

Nature of Treatment:____

Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.

Name:_____________________ Address:_________________________

Nature of Treatment:____

Are you still under the doctor's care?: Yes__ No__ If yes, please provide detail.

Employment History

Current or Most Recent Employer:______________________________

Employer Address:____

Beginning Date:______________ Ending Date:_____________ Position:_____________

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Job Description:____

Beginning Pay Rate:_________ Current or Last Pay Rate:_________________________

Have you ever missed work due to your recent injuries? Yes___ No___

If yes, list the dates you were unable to work. Please provide doctor excuses for these dates. From:______________ To:_____________

Prior Claims and Lawsuits

Please list every claim you have ever made for personal injury or property damage (attach additional page if necessary).

Our adversaries will inquire about your history of legal claims and lawsuits. It is important that you disclose your complete history to us. You still have a right to seek reimbursement for your injuries even if you have been involved in prior legal actions. You will not be penalized by a court or injury if the claims were reasonable and genuine.

Date:____________Nature of Claim:____

Against Whom:____

Result:____

Date:____________Nature of Claim:____

Against Whom:____

Result:____

Date:____________Nature of Claim:____

Against Whom:____

Result:____

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Workers' Compensation

Have you ever filed a claim for Workers' Compensation? Yes__ No__

If yes, please describe your injury:____

____

Date of Injury:____________ Location of Injury:_________________________________

Are you presently receiving payments? Yes __ No__

If yes, Amount:_________________ Frequency:____________________

Who is handling your Workers' Compensation
claim?______________________________

Are you receiving disability payments from sources other than Workers' Compensation?

Yes__ No__ If yes, Amount:_________ Frequency:___________
Source:_____________

Prior Physical Conditions

Please list every physical examination you have had during the **last 10 years** for any injury, including those related to employment, selective service, and armed forces (attach additional page if necessary).

Date:__________ Name of Doctor:___________________

Location:____

Purpose:___________________
Result:____

Date:__________ Name of Doctor:_____________________

Location:____

Purpose:____________________
Result:____

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Date:__________ Name of Doctor:______________________

Location:__
____
Purpose:____________________
Result:____

Date:__________ Name of Doctor:______________________

Location:____

Purpose:____________________
Result:____

Date:__________ Name of Doctor:______________________

Location:____

Purpose:____________________
Result:____

Date:__________ Name of Doctor:______________________

Location:____

Purpose:____________________
Result:____

Date:__________ Name of Doctor:______________________

Location:____

Purpose:____________________
Result:____

Date:__________ Name of Doctor:______________________

Location:____

Purpose:____________________
Result:____

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Prior Accidents and Injuries

Please list all prior accidents, whether they resulted in a claim for damages or not.

Failure to mention other accidents or injuries can undermine a lawsuit, no matter how trivial they may seem.

Date:______________ Location:____

Nature of Accident:____

Extent of Injuries:____

Date:______________ Location:____

Nature of Accident:____

Extent of Injuries:____

Date:______________ Location:____

Nature of Accident:____

Extent of Injuries:____

Date:______________ Location:____

Nature of Accident:____

Extent of Injuries:____

Date:______________ Location:____

Nature of Accident:____

Extent of Injuries:____

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED

Illness or Disease

We must know all about all prior illnesses, either before or since your accident. This is particularly true if there is any connection with your present physical complaints. The defendant will have access to a complete history of your past physical condition as well as your veteran's records, insurance records, and medical/hospital records.

Date:___________Nature of Illness:____

Duration:_____________ Treated by:____

Hospitalized? Yes__ No__ If yes, when?____

Name and address of
hospital:____

Date:___________Nature of Illness:____

Duration:_____________ Treated by:____

Hospitalized? Yes__ No__ If yes, when?____

Name and address of
hospital:____

Date:___________Nature of Illness:____

Duration:_____________ Treated by:____

Hospitalized? Yes__ No__ If yes, when?____

Name and address of
hospital:____

Have you ever had trouble with your eyes? Yes__ No__ Ears? Yes__ No__

If yes, please check all of the following that apply to you:

Glasses/Contacts:___ Artificial Eye:___ Hearing Aid:___ Other:____________________

Have you ever worn a brace or back and neck support? Yes_ No_

Signature: ____Date:______________

PERSONAL INJURY CLIENT QUESTIONNAIRE
CASE EVALUATION CONTINUED
(Internal Office Use Only)

SOL: __ YEARS
DOA:
DAMAGES: $
MEDICAL BILLS: $
OOE: $
LOST OF WAGES: $
PAIN AND SUFFERING:$
TOTAL$