LAW OFFICE
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# AUTOMOBILE COLLISION INTERVIEW REPORT

Date of Injury: _____

| PERSONAL INJURY - CLIENT DATA | |
|---|---|
| Name | |
| Address | |
| City, State, Zip | |
| Email Address | |
| Cell Phone | |
| Home/Work Phone | |
| Soc Sec No. | |
| Date of Birth | |
| Place of Birth | |
| Driver's License No. | |
| Education | |
| Medicare Eligible? | |
| Military Service? | |
| Marital Status, Spouse | |
| Children, Names & Ages | |

| WORK BACKGROUND | |
|---|---|
| Employer | |
| Job Title & Duties | |
| Sup's Name & No. | |
| Payroll Admin. | |
| Length of Employment | |
| Rate of Pay Hours/Week | |
| Time Loss | |
| Changes in Employment | |

| CLIENT'S INSURANCE | | | |
|---|---|---|---|
| Auto Insurance Co. | | | |
| Claim No. | | | |
| Address | | | |
| City/State/Zip | | | |
| Claims Adjuster | | | |
| Phone No. | | | |
| Fax No. | | | |
| Email | | | |
| Policy Limits | Liability | PIP | UIM |
| Health Insurance | | | |
| Subscriber Name & No. | | | |
| Group No. | | | |

| THIRD PARTY'S PERSONAL INFO | |
|---|---|
| Driver's Name | |
| Address | |
| City/State/Zip | |
| Phone No. | |
| Vehicle Owner's Name | |

| THIRD (AT-FAULT) PARTY'S INSURANCE INFO | |
|---|---|
| Auto Insurance Co. | |
| Claim Number | |
| Claims Adjuster | |
| Address | |
| City/State/Zip | |
| Phone No. | |
| Fax No. | |
| Email | |

| FACTS OF THE COLLISION | | |
|---|---|---|
| Date, Day, Time | | |
| Weather, Traffic | | |
| Location | | |
| Facts | | |
| Your Vehicle | Yr/Make/Model | Property Damage<br>$ |
| Other Driver's Vehicle | Yr/Make/Model | Property Damage<br>$ |

| AFTER THE COLLISION | |
|---|---|
| Police Dept. | |
| Officer, Badge No. | |
| Case/Report No. | |
| Citations Issued | |
| Witness | |
| Status/Relationship | |
| Phone No. | |

| INJURIES | | | |
|---|---|---|---|
| *Injured Area* | *Pain Level (1-10)* | *Description/Frequency* | *Still Treating?* |
| Head / Face: | | | |
| Neck: | | | |
| Upper Back: | | | |
| Mid Back: | | | |
| Lower Back: | | | |
| Shoulder: L / R | | | |
| Arm/Hand: L / R | | | |
| Leg: L / R | | | |
| Chest/Abdomen | | | |

| **PROVIDERS** | | Prior? |
|---|---|---|
| *Hospital/ER* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Medical Doctor* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Medical Doctor* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Physical Therapist* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Chiropractor* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Massage* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |
| *Other* | | |
| Address | | |
| Phone No. | | |
| Fax No. | | |

| PRIOR ILLNESSES & INJURIES | |
|---|---|
| *Date (Year/Month)* | *Type of Illness/Area of Injury; Current Condition?* |
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| ADDITIONAL NOTES |
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10/3/18