

CLIENT INTERVIEW SHEET

Client (Needles) No. _____

Date _____

Matter: _____

Referred by: _____

PERSONAL INFORMATION

Name: _____

First

Middle

Last

Address: _____

Street

Apt.

City

State

Zip

How many years at the address above? _____ weeks months years

Home #: _____ Cell#: _____

Email: _____

Date of Birth: _____ Social Security No.: _____ - _____ - _____ (Copy)

DL No.: _____ (Copy) State: _____

Place of Birth: _____

Are you currently Employed? Yes No

If so, please complete the following:

Employer: _____

Address: _____

Street

Apt.

City

State

Zip

Phone No.: _____ Fax #: _____

Position: _____ Length of time employed: _____ Supervisor: _____

Did you miss anytime from work due to the accident? Yes No

Marital Status: Single Married Divorced Widow

Spouse's Name: _____

Address: _____

Street

City

State

Zip

Phone #: _____ Cell #: _____

Dependants: Yes No

If yes, how many/age:

Do you have any social sites (facebook, myspace, twitter, etc.)? Yes No

Have your filed for Bankruptcy? Yes No

If yes, when: _____

GENERAL INFORMATION

PASSENGER INFORMATION

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

WITNESSES

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

Name: _____
 First Middle Last
Address: _____
 Street Apt.

 City State Zip
Relation: _____ Phone #: _____

DEFENDANT INFORMATION

Facility Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

Dates of Service: _____ Still treating? Yes No

Amount of bill: _____ Paid? Yes No
Facility Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

Dates of Service: _____ Still treating? Yes No

Amount of bill: _____ Paid? Yes No
Facility Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

Dates of Service: _____ Still treating? Yes No

Amount of bill: _____ Paid? Yes No
Facility Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

Dates of Service: _____ Still treating? Yes No

Amount of bill: _____ Paid? Yes No

PRIOR INJURIES OR CLAIMS

Type of Injury/Claim: _____

Injuries: _____

Date of Accident: _____

Treated by: _____

Claim or Lawsuit: _____

Amount of Recovery/Settlement: _____

Attorney: _____

Type of Injury/Claim: _____

Injuries: _____
Date of Accident: _____
Treated by: _____
Claim or Lawsuit: _____
Amount of Recovery/Settlement: _____
Attorney: _____

Type of Injury/Claim: _____
Injuries: _____
Date of Accident: _____
Treated by: _____
Claim or
Lawsuit: _____
Amount of Recovery/Settlement: _____
Attorney: _____

CRIMINAL RECORDS

* Any prior arrests, indictments, convictions? Yes No

If yes,

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Notes/ Comments

