Client Intake Form
Motorcycle Accident

Today's Date: ____

First Name: _________________ Middle Name _____________ Last Name: ___________________

Address: ____ City: ___________ State: ________

Home Phone: ___________________Cell Phone: ________________Work Phone:______________

Email Address: ____

Date of Birth: ________________________ SSN:_______________________________________

Married ___ Single ___ Divorced ___ Widowed ___ Minor ___

Spouse's Name: ____

Spouse's Date of Birth: __________________ Spouse's SSN:_______________________________

ACCIDENT DETAILS

Date of Accident: _________________________________ Time of Accident: __________________

What was the street location of the accident? ____

City: ____ State: _____________________________

Description (Year, Make, Model) of your motorcycle: _______________________________________

Describe the damage (including location of damage) to your motorcycle as a result of this accident: _____

____

Were there any passengers on your motorcycle at the time of the accident? Yes _____ No _____

If yes, were they injured? Yes _____ No _____

How many vehicles/motorcycles were involved in the accident? _________________________________

How many people were in the other vehicles? ____

Name(s) of the driver(s) of the other vehicle(s) involved in the accident? _________________________

____

Describe the other vehicle(s) involved in the accident: ______________________________________

Describe the damage (including location of damage) to the other vehicles as a result of this accident: ____

____

Do you know the name of the insurance carrier of the other vehicles/motorcycles involved in this accident? Yes _____ No _____ If yes, please list the name of the insurance company: _______________

Was there a government entity involved in the accident? ____

Did police arrive at the location of the accident? Yes _____ No _____

What police department? ____

Is there a police report number (can be found on accident exchange form)? _________________________

Was anyone given a traffic citation at the scene of the accident? Yes _____ No _____

If yes, who? ____

Describe in detail how this accident happened: ____

____

____

____

____

Please draw a diagram of the accident scene:

Did you talk to any witnesses at the scene of the accident? Yes _____ No _____

If yes, please list any and all witnesses:

Name: ________________ Relation to you: _______ Address: _________________ Phone #: _________

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Name: ________________ Relation to you: _______ Address: _________________ Phone #: _________

Do you have any pictures of the damage to your motorcycle? Yes _____ No _____

Was your motorcycle towed from the scene? Yes _____ No _____

Where is your motorcycle located? ____

Is your motorcycle drivable? ____

Did you report this accident to your insurance agent or company? Yes _____ No _____

Did you give a statement to any insurance company? Yes _____ No _____

If yes, when and what insurance company? ____

Please list any claim numbers you have been given by any insurance carrier for this accident:

Your insurance carrier claim number: ____

Adverse insurance carrier claim number(s): ____

Do you have a property damage estimate? Yes _____ No _____

Do you have UM/UIM coverage under your insurance policy? Yes _____ No ______

If yes, do you know your policy limits for UM/UIM coverage? ___________________________________

Do you have med pay coverage? Yes _____ No _____ If yes, do you know the amount? ______________

INJURIES AND TREATMENT

What injuries did you receive as a result of this accident? _______________________________________

____

Did you go to the hospital as a result of your injuries? Yes _____ No _____

If yes, were you transported from the scene via ambulance? Yes _____ No _____

Provide the name of ambulance company: ____

Provide the name of the hospital: ____

How long did you stay at the hospital? ____

What kind of treatment did you receive from the hospital? _______________________________________

____

Did you have x-rays, MRI or other diagnostic tests? Yes _____ No _____

If yes, please explain what type and the results: ____

Did you receive any broken bones or scarring from this accident? Yes _____ No _____

If so, explain: ____

Have you taken any photographs of your accident injuries? Yes _____ No _____

Please list all other providers you have treated with or are currently treating with as a result of this accident (specialist, chiropractor, primary care physician, physical therapy, rehabilitation)?

Name: ______________________________________ Phone Number:__________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

Name: ____ Phone Number:___________________________

What is the approximate amount of your medical bills due to this accident? $_______________________

Do you have health insurance? Yes _____ No _____What carrier: ________________________________

Have you had any other injuries or medical treatment before this accident? Yes _____ No _____

Are the injuries/medical treatment within the past five years? Yes _____ No _____

If yes, please list year of previous accident, type of accident and type of injuries/medical treatment: _____

____

Were you taking any medication on the date of the accident? Yes _____ No _____

If yes, what medications? ____

Have you had any other injuries after this accident? Yes _____ No _____

If yes, please describe: ____

LOST INCOME OR WAGES

Did you miss work time as a result of this accident? Yes _____ No _____ How much time? ___________

Your employer/occupation: ____

Address: ____

Name of supervisor and telephone number: ____

ADDITIONAL INFORMATION

Have you or are you filing for bankruptcy? Yes: _____ No: _____

Are you paying child support? Yes: _____ No: _____

Do you currently or have you had another attorney in this matter? Yes _____ No _____

If yes, who is/was your other attorney? ____

Emergency contact information:

Please provide two names and phone numbers of close relatives that do not live with you:

Name: __________________________ Phone Number: _____________________ Relation: ____________

Name: __________________________ Phone Number: _____________________ Relation: ____________

How did you hear about us? ____

I____________________________ understand that this is a **free consultation** about my accident and that I am not represented until I speak with the attorney who agrees to accept my case and I sign a fee agreement. I understand that my case may or may not be accepted by the attorney.

Sign Name: _____________________________ Date: ____

Print Name: ____________________________ Date: ____