



LINGENBRINK  
L A W

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**PERSONAL INJURY QUESTIONNAIRE**  
(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

Phone No. (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email Address \_\_\_\_\_

MySpace/Facebook/Website \_\_\_\_\_

Which form of communication is the best to reach you on?  Home  Work  Cell  Email

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Marital Status M D S W Spouse Name \_\_\_\_\_

Description of Injury \_\_\_\_\_

Please Check the Box(s) that Pertain to Your Injuries:

- |  |   |                                       |                                   |
|--|---|---------------------------------------|-----------------------------------|
| Loss of Consciousness <input type="checkbox"/> | Soft Tissue <input type="checkbox"/>    | Bruising <input type="checkbox"/>     | Scarring <input type="checkbox"/> |
| Head Injury <input type="checkbox"/>           | Radiating Pain <input type="checkbox"/> | Lacerations <input type="checkbox"/>  |                                   |
| Headaches <input type="checkbox"/>             | Disc Injury <input type="checkbox"/>    | Broken Bones <input type="checkbox"/> |                                   |

Treatment Since Accident:

- |   |   |   |   |
|---|---|---|---|
| Ambulance <input type="checkbox"/>          | Medical Doctor <input type="checkbox"/> | Physical Therapy <input type="checkbox"/> | Surgery <input type="checkbox"/>        |
| Emergency Room <input type="checkbox"/>     | Naturopath <input type="checkbox"/>     | Massage Therapy <input type="checkbox"/>  | Future Surgery <input type="checkbox"/> |
| Hospital Admission <input type="checkbox"/> | Chiropractor <input type="checkbox"/>   | Acupuncture <input type="checkbox"/>      |   |

Prior Accident(s): Date(s) \_\_\_\_\_

Prior L&I claim(s): Date(s) \_\_\_\_\_

Other Medical History \_\_\_\_\_

Family Doctor \_\_\_\_\_

Interests/Hobbies \_\_\_\_\_

Education \_\_\_\_\_

Children (s) Name\ages \_\_\_\_\_

Driver's License Number \_\_\_\_\_

**Accident Information**

Who can we thank for your referral? \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time of Day \_\_\_\_\_ a.m. p.m.

Location of Accident: (Name of street, road or highway) \_\_\_\_\_

(Intersection) \_\_\_\_\_

(County) \_\_\_\_\_ (City) \_\_\_\_\_

(Other) \_\_\_\_\_

Direction:  North  South  East  West

Police Investigated:  State Patrol  County  City  No Investigation  Other

Case Number \_\_\_\_\_ Officer's Name \_\_\_\_\_

Were citations issued?  Yes  No

If so, to Who and What Violation \_\_\_\_\_

Were you the:

Driver  Passenger  Pedestrian  Motorcyclist  Bicyclist   
Wearing Seatbelt  Airbag Deployed

No. of vehicle's involved: \_\_\_\_\_

No. of people in your vehicle: \_\_\_\_\_ Your Speed: \_\_\_\_\_

No. of people in other vehicle: \_\_\_\_\_ Other speed: \_\_\_\_\_

Describe Accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Had you consumed any Alcohol/ Drugs/ Medication 24hrs prior to the accident:  Yes  No  
If yes, what and how much? \_\_\_\_\_

**Defendant / Insurance Information**

Name of Defendant \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Insurance Carrier** \_\_\_\_\_ Policy / Claim No. \_\_\_\_\_

Name of Insurance Adjuster \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

Phone \_\_\_\_\_

Acting Within Scope of Employment:  Yes  No Company Name \_\_\_\_\_

**Your Insurance Information**

**Auto Insurance Carrier** \_\_\_\_\_ Policy No. \_\_\_\_\_

LIABILITY \_\_\_\_\_ UM/UIM \_\_\_\_\_ PIP \_\_\_\_\_

Policy Holder Name (if different than self) \_\_\_\_\_

Name of Insurance Adjuster \_\_\_\_\_ Claim No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

Phone No. \_\_\_\_\_

**Medical Insurance** \_\_\_\_\_ Plan No. \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
(street) (city) (state) (zip code)

DSHS -  Yes  No

MEDICARE -  Yes  No

Acting Within Scope of Employment:  Yes  No L&I Claim No.: \_\_\_\_\_

**Witness Information**

Name of Witness \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Employment Info.**

**Current Employer** \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Phone No.** \_\_\_\_\_ **Supervisor's Name** \_\_\_\_\_

Title of Your Position \_\_\_\_\_ Salary \$ \_\_\_\_\_ /year \$ \_\_\_\_\_ /month

Description of Duties \_\_\_\_\_

Has accident caused you to lose time from work?  Yes  No

**Employer at time of accident, if different from above** \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

Employer's Phone No. \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Title of Your Position \_\_\_\_\_ Salary \$ \_\_\_\_\_ /year \$ \_\_\_\_\_ /month

Description of Duties \_\_\_\_\_

Has accident caused you to lose time from work?  Yes  No

**Property Damage Information**

Is Property Damage an Issue?  Yes  No

If so, has your Property Damage been Resolved:  Yes  No

If so, by who? \_\_\_\_\_

Your vehicle description: Make\Model \_\_\_\_\_

Your property damage amount: \$ \_\_\_\_\_

Was your vehicle towed?  Yes  No If so, by whom? \_\_\_\_\_

Others vehicle description: Make\Model \_\_\_\_\_

Their property damage amount: \$ \_\_\_\_\_

Was their vehicle towed?  Yes  No If so, by whom? \_\_\_\_\_

**Treatment Resulting From Current Accident**

**Ambulance** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Hospital** \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Doctor's Name** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Current Treatment Frequency** \_\_\_\_\_  
(Visits per week / month) (Next Follow-up Exam)

**Doctor's Name** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Current Treatment Frequency** \_\_\_\_\_  
(Visits per week / month) (Next Follow-up Exam)

**Doctor's Name** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Current Treatment Frequency** \_\_\_\_\_  
(Visits per week / month) (Next Follow-up Exam)

**Doctor's Name** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Current Treatment Frequency** \_\_\_\_\_  
(Visits per week / month) (Next Follow-up Exam)

**Doctor's Name** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Current Treatment Frequency** \_\_\_\_\_  
(Visits per week / month) (Next Follow-up Exam)

**Pharmacy** \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(street) (city) (state) (zip code)

**Other Out of Pocket Expenses** \_\_\_\_\_  
\_\_\_\_\_

**Bankruptcy**

Have you ever filed or do you plan to file bankruptcy? \_\_\_\_\_

Name of bankruptcy attorney \_\_\_\_\_

Street address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Emil Address \_\_\_\_\_

Date Filed: \_\_\_\_\_

Case Number: \_\_\_\_\_

Court Where Filed: \_\_\_\_\_

Please add in the space below any additional information or comments relative to your accident which you feel will help us in obtaining a satisfactory settlement for you. For example, consider any statements made by the defendant or yourself, remarks of the police investigating the accident, and how the accident has affected your lifestyle, job responsibilities, and /or family life.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Space Below For Office Use Only