GALLAGHER | KRICH
TRUSTED ADVOCATES

Please print out and fill out the form below. Feel free to use additional pages if needed. For clarity, please label continuation responses according to section and item numbers.

PERSONAL INJURY INTAKE

1) CLIENT INFORMATION

Last name: _____ First name: _____ MI: _____

Date of Birth: _____ SSN: _____

Street Address: _____

State: _____ Zip: _____

Home/Cell Phone: _____ Work Phone: _____

E-mail: _____

2) EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Street Address: _____

State: _____ Zip: _____

Weekly/Biweekly Salary: _____ Date Employment Commenced: _____

No. of Hours Worked Per Day: _____ No. of Days Worked Per Week: _____

Supervisor: _____ Phone No.: _____

Last Day Worked Before Accident: _____

Date Returned: _____ Light/Restricted Duty?: _____

How Long Were You Confined To Bed: _____

How Long Were You Confined Home: _____

3) ACCIDENT INFORMATION

Date of Accident: _____ Day: _____ Time: _____

Location Of Accident: _____

Accident Report No.: _____

Officer's Badge No.: _____

Officer's Name: _____

4) WITNESSES

Witness #1 Name: _____

Address: _____

Phone Number: _____

Witness #2 Name: _____

Address: _____

Phone Number: _____

Witness #3 Name: _____

Address: _____

Phone Number: _____

5) VII. VEHICLE INFORMATION

☐ I was the _____ in vehicle # 1 (Owner/Operator/Passenger).
☐ I was a pedestrian.

Vehicle No. 1: (Host Vehicle)

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN #: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Address: _____

Operator: _____

Address: _____

Carrier/Insurance Code: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 2:

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN #: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Address: _____

Operator: _____

Address: _____

Carrier/Insurance Code: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

Vehicle No. 3:

Vehicle Plate No.: _____ Vehicle's Year: _____

Vehicle's Make: _____ Vehicle's Model: _____

Vehicle's VIN #: _____

Owner's Name: _____

Owner's Address: _____

Leaseholder's Name: _____

Address: _____

Operator: _____

Address: _____

Carrier/Insurance Code: _____

Address: _____

Policy Holder: _____ Policy No.: _____

Effective Date of Policy: _____ Expiration Date of Policy: _____

6) Hospitals

Medical Care: _____

Injuries Sustained: _____

Emergency Care at Scene: Yes ☐ No ☐
Ambulance: Yes ☐ No ☐

Hospital #1: _____

Date of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

Hospital #2: _____

Date of Treatment: _____ Date of Discharge: _____

Address: _____

Treatment Type: ☐ ER ☐ Admission ☐ Outpatient ☐ Clinic Visit

7) . Physicians

1. Doctor's Name: _____ Specialty: _____

Address: _____

Phone: _____ E-mail: _____

Date of First Visit: _____

2. Doctor's Name: _____ Specialty: _____

Address: _____

Phone: _____ E-mail: _____

Date of First Visit: _____

3. Doctor's Name: _____ Specialty: _____

Address: _____

Phone: _____ E-mail: _____

Date of First Visit: _____

8) Documents

Please check off any of the below documents that you may have in your possession and attach copies of the following documents:

- ☐ Driver's License
- ☐ Car Insurance Card
- ☐ Medical Records
- ☐ Accident Report
- ☐ Photographs of Defendant Vehicle
- ☐ Health Insurance Card
- ☐ Declarations Sheet
- ☐ Medical Bills
- ☐ Photographs of Client Vehicle
- ☐ Photographs of Injuries