

LAW OFFICES OF WAGNER & JONES  
NEW CLIENT INTAKE SHEET

(PERSONAL INJURY)

Referred By: \_\_\_\_\_ Date of Call: \_\_\_\_\_

*Please complete the entire form*

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Mr/Ms. \_\_\_\_\_ DOB: \_\_\_\_\_  
\_\_\_\_\_ SS#: \_\_\_\_\_  
\_\_\_\_\_ DOI: \_\_\_\_\_

Phone number: \_\_\_\_\_ Message phone: \_\_\_\_\_

1. How did the accident occur? \_\_\_\_\_  
\_\_\_\_\_
2. Describe your injuries resulting from this accident: \_\_\_\_\_  
\_\_\_\_\_
3. Have you sought medical attention? Y or N Still treating? Y or N  
When? \_\_\_\_\_
4. Total medical bills incurred to date? \_\_\_\_\_
5. Doctor(s) Name, address, & phone number:  
\_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_
6. Medical diagnosis? \_\_\_\_\_
7. Police report? Y or N Accident report? Y or N
8. Please list your lost wages to date: \_\_\_\_\_  
Your employer: \_\_\_\_\_  
Rate of pay: \_\_\_\_\_ Date of Hire? \_\_\_\_\_
9. Do you have a claim for unpaid meal time, over time, vacation time, sick  
time or breaks? Yes \_\_\_\_\_ No \_\_\_\_\_

FOR AUTO ACCIDENTS:

1. Estimate amount in dollars to repair? \_\_\_\_\_
2. Part of auto damaged? \_\_\_\_\_
3. Location of accident? \_\_\_\_\_
4. Other person(s) have ins.? Y or N Do you have ins.? Y or N

5. Your insurance agent's name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: (        ) \_\_\_\_\_

6. Defendant's insurance information? \_\_\_\_\_

Claim No.: \_\_\_\_\_ Adjuster: \_\_\_\_\_

7. Pictures?      Yes      or      No

8. What of? \_\_\_\_\_

**FOR SLIP & FALL ACCIDENTS:**

1. Type of shoe worn? \_\_\_\_\_

2. What caused the fall? \_\_\_\_\_

3. Where did you fall? \_\_\_\_\_

Additional Notes

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