**PERSONAL INJURY CONSULTATION DOCUMENT**   
**MOTOR VEHICLE ACCIDENT**

**Client Information**

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| Full Name: | | Email Address: | | |
| Contact Number: | | Occupation: | | |
| Employer: | |  | | |
| Address: | Unit No. | City/Town | Province/County/State | Zip Code/Postal Code |

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| **Has the Client Contacted Another Attorney?**  Yes  No |
| **Name of Attorney:** |

**Accident Information**

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| Date of Accident: | Time of Accident: |
| Location of Accident: | |
| Specify the nature of the accident (e.g., car collision, slip and fall, equipment malfunction): | |
| Provide a detailed account of how the accident happened: | |
| Provide list of injuries: | |
| Was anyone else injured in the same accident or in the same way? If yes, how many? | |
| Did that accident result in:  Estimated Wage loss, if yes, please provide:   * Number of Days Missed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Dates of missed work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Total wages lost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Loss of earning capacity, if yes, please provide details:   * Nature of the injury impacting earning capacity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Estimated loss in future earnings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Loss of life, if yes, please provide the following information:   * Name of the deceased: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Date of death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Relationship to the deceased (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Contact information for the estate or next of kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Loss of using property, if yes, please describe:   * Type of property: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Estimated duration of loss of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Estimated cost to replace or repair the property: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Property damage,if yes, please provide the following:   * Description of damaged property: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Estimated repair or replacement cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Is the property insured?  Yes  No * If insured, provide the insurance company and policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Other Damages, if yes, please describe:   * Type of damage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Estimated financial impact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Are you still incurring costs or loss of wages from this accident? | |

**Who Injured You**

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| This is a business or organization.  This is a government agency. |
| Provide contact details for this party: |
| Is there more than one party responsible for your injury? If so, how many? |
| Provide contact details for each party: |
| Have you had contact with these parties about the injury? If so, please describe the contact below. |

**Medical Treatment Received**

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| Type of Treatment: |
| Name of Hospital/Clinic: |
| Date of Treatment: |
| Ongoing Medical Issues: |
| Any previous injuries relevant to this accident? Yes  No  Provide details: |
| Do you have documents relating to the injury?  Police statements or reports  Medical records  Insurance paperwork |
| Do you currently have a doctor treating this injury? |