**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**

|  |  |
| --- | --- |
| 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 [ ]  NoProvide 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? |