**PERSONAL INJURY DEPOSITION CHEAT SHEET - PLAINTIFF, MOTOR VEHICLE ACCIDENT**

**Personal Information**

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| --- | --- |
| Full Name: | Email address: |
| Address:Address at the time of the accident (if different):  |
| Phone number: | Date of birth: |
| Marital Status:  | Length of relationship: |
| Children/Dependants: | Ages:  |
| Driver’s license: | Class: Any restrictions:  |
| Medical coverage: [ ]  Yes [ ]  No | If yes, provide details: |
| Criminal history: [ ]  Yes [ ]  No | If yes, provide details: |
| Social media usage: [ ]  Yes [ ]  No | If yes, which applications: |

**Employment Information**

|  |  |
| --- | --- |
| Occupation:  | Job title/duties: |
| Employer: | Contact information for the employer: |
| Length of employment: | Name of immediate supervisor: |
| Remuneration: | Hours regularly worked: |
| Future prospects: | Benefits: |

**Vehicle Information**

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| Year and model of vehicle involved in the accident: |
| Owner: |
| If the plaintiff is not the owner, did they have permission to use it? |
| Vehicle in good working condition before the accident? |
| Did the accident result in damage to the vehicle?[ ]  Yes [ ]  No | If yes, provide details: |

**Plaintiff’s Condition Before the Accident**

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| How many hours of sleep evening before the accident: |
| Any prescription drugs in 24 hours before the accident: |
| Any non-prescription drugs in 24 hours before the accident: |
| Other illnesses or disability affecting driving within 24 hours before the accident: |

**The Accident**

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| --- | --- |
| Date of accident: | Time of accident: |
| Location of the accident: | * Familiarity with accident area:
* Characteristics of location (e.g., crosswalks, intersections, etc.):
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| Coming from: |
| Going to: |
| Speed at the time of the accident:  | Speed limit on the road: |
| Weather conditions at the time of the accident: |
| Surface conditions at time of the accident: |
| Distractions in the vehicle at the time of the accident: |
| Lighting at the time of the accident: |
| Wearing a seatbelt at the time of the accident:  | Type of seatbelt: |
| Required to wear prescription glasses or contacts?[ ]  Yes [ ]  No | If so, wearing them at the time of the accident? |
| Plaintiff to describe in own words how the accident happened: |
| Any opportunity for evasive action?[ ]  Yes [ ]  No | If so, was evasive action taken? |
| How far did vehicles travel after the point of impact? |
| Airbags deployed? |
| Other passengers in the vehicle? [ ]  Yes [ ]  No | If so, location and what happened to them: |

**Following the Accident**

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| What happened to the plaintiff in the accident: |
| Did the plaintiff brace before impact: |
| Did the plaintiff strike anything in the vehicle: |
| Any immediate symptoms following the accident: |
| If passengers in the vehicle, were passengers injured: |
| What happened following the accident: |
| Emergency services attended the scene: [ ]  Yes [ ]  No | If so, which ones: |
| Spoke to anyone following the accident: [ ]  Yes [ ]  No | If so, who: |
| Spoke to the defendant following the accident:[ ]  Yes [ ]  No | If so, details of conversation: |
| Observations of the defendant’s condition following the accident: |
| Observations of damage to the defendant’s vehicle following the accident: |
| Statements provided following the accident:• When:• To whom:• What was said: |

**Injuries**

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| Identify specific injuries attributable to the accident: |
| Location and nature of pain: |
| When the problem began: |
| How long it lasted (or whether it is ongoing): |
| Whether constant or intermittent: |
| Whether particular movements or activities cause aggravation: |
| Other pain and health problems (e.g., headaches, lack of concentration, dizziness, nausea): [ ]  Yes [ ]  No | If yes, specify when symptoms began and howlong they lasted: |
| Need for medical assistance devices (e.g., cane, crutches, wheelchair): [ ]  Yes [ ]  No | If yes, duration and frequency of use: |
| Changes in appearance (e.g., weight gain, scars, disfigurement): |
| Changes in emotional or psychological state: |

**Effect Of Injuries on Plaintiff’s Employment**

|  |  |
| --- | --- |
| Did the plaintiff take time off work following the accident? [ ]  Yes [ ]  No | If yes, provide details: |
| How much time off work: |
| Did the doctor advise the plaintiff not to work: |
| Did the plaintiff lose entitlement to benefits, vacation, sick days: |
| Did the plaintiff collect disability while off work: |
| Any adverse impact on employment (including long-term earnings or career aspirations): |
| Other negative impacts on employment (e.g., being denied promotion):  |
| Has the plaintiff been accommodated at work: |
| Can the plaintiff still do the same type of work as before? |

**Effect Of Injuries on Plaintiff’s Domestic and Recreation Activities**

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| --- | --- |
| Was the plaintiff unable to participate in any domestic or recreational activities following the accident?[ ]  Yes [ ]  No | If yes, provide details: |
| Have activities been resumed or attempted? |
| Has the plaintiff canceled domestic or recreational plans due to the accident (e.g., canceled vacations, delayed family planning, etc.) [ ]  Yes [ ]  No | If yes, provide details: |
| Have family members provided domestic services tothe plaintiff they would otherwise not have provided?[ ]  Yes [ ]  No | If yes, provide details: |

**Plaintiff’s Medical History**

|  |  |
| --- | --- |
| Pre-existing illnesses and conditions (including psychological or psychiatric illness) requiring medical treatment? [ ]  Yes [ ]  No | If yes:• Attending physician:• Date/time frame:• Nature of illness and duration:• Treatment: |
| Medication before the accident?[ ]  Yes [ ]  No | If yes:• Dosage:• Prescribed by whom: |
| Did the accident aggravate an old injury or illness?[ ]  Yes [ ]  No | If yes, provide details: |
| Have there been intervening medical conditions or injuries since the accident? [ ]  Yes [ ]  No | If yes, provide details: |

**Plaintiff’s Treatment**

|  |  |
| --- | --- |
| Treatment following the accident? [ ]  Yes [ ]  No | If yes, obtain:* Attending physician and contact information:
* Date/time frame:
* Complaints:
* Treatment:
 |
| Has treatment helped or hindered recovery? |
| If treatment is discontinued, why? |
| Plaintiff complying with treatment recommendations? |
| Have treators provided a diagnosis or prognosis regarding the plaintiff’s condition? |
| Any x-rays, MRIs, CT scans, etc.? [ ]  Yes [ ]  No | If yes, provide details: |
| Are any medications prescribed or taken?[ ]  Yes [ ]  No | If yes, provide details: |
| Are any future surgeries or appointments planned? [ ]  Yes [ ]  No |
| Prognosis? [ ]  Yes [ ]  No |  |
| Outstanding medical bills/liens?[ ]  Yes [ ]  No | If yes, provide details: |