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Form templates

Personal Injury (Premises)

Waldron/Tate/Land

Waldron Tate

Bowen Land LLC

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St., 5th Floor

Indianapolis, IN

46204

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On behalf of Waldron Tate Bowen Land LLC, ("Firm"), thank you for giving us the opportunity to represent you. Our Firm is committed to providing top quality legal representation and services customized to each client's needs. Please read the privacy policy below, and then fill out this form in its entirety.

Privacy Policy

All information received from a client is strictly confidential. Our firm takes every step possible to protect your privacy. The data submitted via this form is encrypted and secured using industry-standard 256-bit SSL encryption.

Your Social Security number and other personal information will only be used only when necessary in limited use during the course of your case.

Social Security numbers are most often used to positively identify parties. Most courts require Social Security numbers of all parties in a case. Some other examples of how this information may be used include:

- initial service
- in court orders
- in required reports or other documents filed with the State
- to gather medical and employment records

If you have any questions, please don't hesitate to contact our law office. We look forward to working with you!

Contact information: Name and Address

Prefix**First name *****Middle name****Last name *****Date of birth**

Email (required when in public form)**Phone number****Street address****City****State/Province****Zip/Postal code****Social Security Number:****Does anyone else live with you at your current address?**

- ☐ Yes
☐ No

All Addresses for last 10 years:**Are you married?**

- ☐ Yes
☐ No

Are you divorced?

- ☐ Yes
☐ No

Do you have children?

- ☐ Yes
☐ No

Have you ever gone by any other names? (e.g., maiden name)

- ☐ Yes
☐ No

Secondary Contact Name (Optional):

Please enter your response

Secondary Contact Phone Number (Optional):

Please enter your response



Driver's License State and Number:

Please enter your response

Have you ever filed for bankruptcy?

- ☐ Yes
☐ No

Incident Information

Date of Incident



Time of Incident (also include am or pm)

Please enter your response

City of Incident

Please enter your response

County of Incident

Please enter your response

Location of Incident

Please enter your response

Were emergency personnel called to the scene?

- ☐ Yes
☐ No

Was an accident or incident report filed?

- ☐ Yes
☐ No
☐ Unknown

Describe how the incident occurred:

Please enter your response

Witness Information

If applicable

Witness 1

- ☐ Fill out witness information
- ☐ Not applicable

Witness 2

- ☐ Fill out witness information
- ☐ Not applicable

Witness 3

- ☐ Fill out witness information
- ☐ Not applicable

Witness 4

- ☐ Fill out witness information
- ☐ Not applicable

Names of friends/family/colleagues who can testify as to your condition pre/post incident and/or saw you through recovery:

Please enter your response

Injuries

Please describe any and all aches, complaints, discomforts and disabilities, as a result of the incident, in detail.

Please enter your response

Check all symptoms you have noticed since the incident:

☐ Headache ☐ Neck pain ☐ Hands cold ☐ Loss of balance ☐ Depression ☐ Pins & needles in arms or legs
☐ Nervousness ☐ Numbness in toes ☐ Chest pain ☐ Neck stiffness ☐ Stomach upset ☐ Fainting ☐
Light sensitivity ☐ Ears ringing ☐ Shortness of breath ☐ Bruising ☐ Dizziness ☐ Sleeping problems ☐
Back pain ☐ Memory loss ☐ Fatigue ☐ Tension ☐ Muscle pain

Did you go to the hospital?

- ☐ Yes
☐ No

Did you go by ambulance?

- ☐ Yes
☐ No

Did they take x-rays or other imaging?

- ☐ Yes
☐ No

Have you seen a doctor since the date of the incident, other than at the emergency room?

- ☐ Yes
☐ No

Injury History

Have you had any accidents or injuries before this collision?

Injury #1:

- ☐ Fill out injury information
☐ Not Applicable

Injury #2:

- ☐ Fill out injury information
- ☐ Not Applicable

Injury #3:

- ☐ Fill out injury information
- ☐ Not Applicable

Injury #4:

- ☐ Fill out injury information
- ☐ Not Applicable

Additional Past Injury Information:

Please enter your response

Are you currently on any medications?

- ☐ Yes
- ☐ No

Medical Provider History

Please provide a list of all medical providers you have seen for the last 5 years. This includes chiropractors, pharmacies, primary care providers, hospitals, specialists, etc.

Name and Address of all medical providers for the last 5 years:

Please enter your response

Loss of Earnings

If you anticipate loss of earnings due to accident related injuries, please complete the following:

Were you working at the time of the incident?

- ☐ Yes
☐ No

Did you miss work because of your injuries?

Please enter your response

If yes, how much time from work did you miss?

Please enter your response

How much money did you lose as a result of missed work?

Please enter your response

Additional Information:

Any additional information you think would be helpful?

Please enter your response

Document Request

Please upload or email any documents that would be helpful such as:

Medical Records
Medical Bills
Insurance Correspondence
Accident Report
Police Report
Photographs
Front and Back of Driver's License

Calendar, diary, or notes related to the incident

Would you like to attach the above documents now?

- ☐ Yes
- ☐ I will send them at a later time

THANK YOU

Thank you so much for completing this intake questionnaire. This information will be extremely helpful in moving forward with your case. We will contact you soon to discuss any further questions related to your answers.

Please click the **SUBMIT** button below when you have finished answering all questions.

This is a form preview