GUILLORY HARGRAVE & LACOMBE, LLC
CLIENT INFO SHEET
PERSONAL INJURY

CLIENT NAME:_____Date:_____
First Middle Maiden Last

Date of Birth:_____ Social Security No. _____

Address:_____
Street City Parish State Zip

Phone: (___)_____ Alternate Phone: (___)_____

E-Mail Address:_____

Employer:_____

Employer Address:_____
Street City State Zip

Driver's License No.: _____

Highest Education Level: _____

Interests\Hobbies: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Spouse Name: _____ Date of Marriage:_____

Dependents:

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Has this accident caused you lose time from work? ☐ Yes ☐ No

If yes, how much work have you missed? _____

Were you acting within the scope of your employment at the time of the accident? ☐ Yes ☐ No

ACCIDENT INFORMATION

Date of accident: _____ Time of day: _____ a.m./p.m.

Location of accident: (Name of street, road or highway):_____

Intersection:_____

City: _____ Parish:_____

Investigating Agency: ☐ LSP ☐ CPSO ☐ LC City Police ☐ Sulphur City Police ☐ Other

Do you have a copy of the Accident Report ? ☐ Yes ☐ No

Do you have any photographs? ☐ Yes ☐ No

Were any citations issued? ☐ Yes ☐ No

If so, to whom and for what violation? _____

_____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

If passenger, position in vehicle:_____

Other Driver Name:_____

Other Driver Address:_____
Street City Parish State Zip

Have you given a statement to anyone about this accident? ☐ Yes ☐ No

If yes, who?_____

Was anyone transported by ambulance from the scene of the accident? ☐ Yes ☐ No

If yes, who?_____

Were any vehicles undriveable and need towing from the scene of the accident? ☐ Yes ☐ No

If yes, which vehicle?_____

Describe the accident in your own words: _____

_____

_____

_____

INJURY INFORMATION

Location of Injury on Body: _____

Description of Injury: _____

When did you first feel pain?_____

Please check all that relate to your injuries:

☐ Loss of Consciousness	☐ Soft Tissue	☐ Bruising	☐ Scarring
☐ Head Injury	☐ Radiating Pain	☐ Laceration(s)	☐ Headaches
☐ Disc Injury	☐ Broken Bone(s)	☐ Sprain(s)	☐ Strained muscle(s)
☐ Torn ligaments	☐ Torn tendons	☐ Torn muscle	☐ Whiplash

☐ Other (please describe):_____

MEDICAL TREATMENT INFORMATION

Please check all of the following you have had since the accident and provide the requested info:

☐ Transportation by Ambulance. Date and facility transported to:_____

_____

☐ Examination/treatment by a medical doctor. Name and dates:_____

_____

☐ Physical Therapy. Name and date range:_____

_____

☐ Surgery. Name of surgeon, facility, type of surgery, date: _____

_____

☐ Emergency Room. Date, facility, reason:_____

_____

☐ Naturopath. Name, dates, treatments administered: _____

_____

☐ Massage Therapy. Name and dates:_____

_____

☐ Future Surgery Recommendation. Name of recommending doctor, type of surgery:_____

_____

☐ Hospital Admission. Name of facility, reason, length of stay: _____

_____

☐ Chiropractor. Name, date range, areas treated:_____

_____

☐ Acupuncture. Name, dates, areas treated:_____

_____

☐ Imaging (MRI, CT, X-ray, etc.). Type, facility, area of body, ordering doctor: _____

_____

☐ Other Testing. Type, facility, area of body, ordering doctor:_____

_____

☐ Prescriptions. Names and duration:_____

_____

☐ Over the Counter medication. Names and duration:_____

HEALTH INSURANCE INFORMATION

Do you have private health insurance? ☐ Yes ☐ No

If yes, who is your insurance carrier?_____

Member ID Number:_____

Do you have Medicaid or Medicare? ☐ Yes ☐ No

If yes, which one and what is your ID number?_____

Has your insurance company/Medicaid/Medicare paid for any treatment as a result of this accident?

☐ Yes ☐ No

PROPERTY DAMAGE INFORMATION

Was your vehicle or any other property of yours damaged in this accident? ☐ Yes ☐ No

If so, has your property damage claim been resolved yet? ☐ Yes ☐ No

If yes, by who? _____

If no, please give the following information:

Vehicle year, make, and model: _____

Repair estimate: $_____ done by _____

AUTO INSURANCE INFORMATION:

Your insurance company: _____

Policy Number: _____

Liability coverage limits: _____

Uninsured/underinsured motorist coverage limits:_____

Med pay limits:_____

Adjuster name (if one has been assigned for this accident):_____

Claim number:_____

SOCIAL NETWORKING SITES:

Please list all social networking sites you have accounts or profiles on (including but not limited to Facebook, Twitter, Snapchat, TikTok, LinkedIn, Instagram, YouTube, Pinterest, Tumblr, Flickr, etc.)

_____

_____

How did you hear about us? _____

*I UNDERSTAND THAT THIS IS AN INITIAL CONSULTATION ONLY.

_____ _____

SIGNATURE DATE