STANDEFFER LAW, LLC
CIVIL ACTION QUESTIONNAIRE

DATE: _____ ATTORNEY: _____ PARALEGAL: _____

NAME: _____

ADDRESS: _____

_____

SSN: _____ DATE OF BIRTH: _____

HOME PHONE NO.: _____ WORK PHONE NO.: _____

EMPLOYER: _____

HOW LONG AT PRESENT JOB: _____ POSITION: _____

SALARY: _____ TIME LOST DUE TO ACCIDENT: _____
Hours/days/weeks/months

SPOUSE'S NAME: _____

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ AM/PM

PLACE OF ACCIDENT: _____

WHO WAS THE ACCIDENT REPORTED TO: _____
Police/EMS

DESCRIBE HOW THE ACCIDENT HAPPENED? _____

_____

_____

DID YOU GO TO THE HOSPITAL? YES/NO (Circle one)

If yes, which hospital: _____

HOW WERE YOU TRANSPORTED TO THE HOSPITAL? AMBULANCE/CAR (Circle one)

If you were taken by Ambulance, which Ambulance Company transported you?

_____

DESCRIBE THE INJURIES SUSTAINED AS A RESULT OF THE ACCIDENT.

_____

_____

_____

WERE THERE ANY WITNESSES TO THE ACCIDENT? YES/NO (Circle one)

If yes, please list their names, addresses and telephone numbers:

_____

_____

_____

DID MEDICAL INSURANCE PAY ANY OF THE MEDICAL BILLS? NO YES

PLEASE STATE NAME AND ADDRESS OF THE PROVIDER:_____

WAS THE PATIENT RECEIVING BENEFITS FROM MEDICARE? NO YES

MEDICARE ID NUMBER:_____

WAS THE PATIENT RECEIVING BENEFITS FROM MEDICAID? NO YES

MEDICAID ID NUMBER:_____

WAS THE PATIENT RECEIVING BENEFITS FROM THE VETERANS' ADMINISTRATION?
NO YES

VA ID NUMBER:_____

WHAT ARE THE APPROXIMATE TOTAL MEDICAL BILLS AS A RESULT OF THIS ACCIDENT? _____

DID THE VICTIM MISS ANY WORK AS A RESULT? NO YES

IF ANSWER IS YES, TOTAL AMOUNT OF LOST WAGES $_____

LIST ANY OTHER EXPENSES OR DAMAGES AS A RESULT OF THE ALLEGED ACCIDENT
_____

_____

NAME OF ALL DOCTORS, HOSPITALS, OR OTHER PROVIDERS WHO HAVE PROVIDED TREATMENT AS A RESULT OF THIS INCIDENT:

NAME _____

ADDRESS _____

DATES OF TREATMENT _____

COMPLICATIONS _____

NAME TREATED UNDER _____

DATE OF LAST TREATMENT _____

NAME _____

ADDRESS _____

DATES OF TREATMENT _____

COMPLICATIONS _____

NAME TREATED UNDER _____

DATE OF LAST TREATMENT _____

NAME _____

ADDRESS _____

DATES OF TREATMENT _____

COMPLICATIONS _____

NAME TREATED UNDER _____

DATE OF LAST TREATMENT _____

SOCIAL NETWORKING:

DO YOU USE ANY TYPE OF SOCIAL NETWORKING SITES SUCH AS
MYSPACE, FACEBOOK, TWITTER, ETC. IF SO PLEASE INDICATE WHICH ONE.

ANY OTHER INFORMATION WHICH YOU THINK WE NEED TO KNOW ABOUT YOUR CASE:

TO BE FILLED OUT BY ATTORNEY OR PARALEGAL
(OFFICE USE ONLY)

1. Previous Hospitalization in the past 10 years:_____

_____

_____

2. Has client ever been in a Mental Hospital or Institutionalized? YES/NO

   If yes: Name, Address, Dates, Reason for hospitalization, and all treating physicians

_____

_____

_____

_____

3. Has client ever filed a Worker's Compensation claim? YES/NO

   If yes, please explain:_____

_____

_____

4. Has client ever been convicted of a criminal offense? YES/NO

   If yes, please explain:_____

_____

_____