

DECAMILLIS & MATTINGLY, PLLC

INITIAL CLIENT INTAKE FORM

* Please allow the receptionist to make a copy of your license and insurance card in order to expedite the processing of your case.

1. I am here to meet with (circle one): John A. DeCamillis Amanda Hartley
 Robert D. Mattingly Doug Mory

2. Today's Date: _____

3. Full name: _____

4. Current Address: _____

5. Date of Birth: _____ Social Sec. No. _____

6. Home Phone: _____

Cell Phone: _____

Work Phone: _____

Other Phone: _____

7. Who referred you to this office?

8. If you cannot reach me at the above phone number or address, an alternative contact person and address is as follows:

FACTS ABOUT THE ACCIDENT

1. Do you have a copy of the police report? Yes No

2. Date of the accident: _____

3. Where did the accident happen?

4. How did the accident happen?

5. How many vehicles were involved in the accident?

6. Please list the names of all the people in the car with you:

AUTOMOBILE INSURANCE

- | | | | |
|----|--|-----|----|
| 1. | Did you own the car you were riding in? | Yes | No |
| 2. | Did the car you were in have insurance? | Yes | No |
| 3. | What is the name of the insurance company for the car you were in? | | |

- | | | | |
|----|--|-----|----|
| 4. | Did the OTHER CAR have insurance? | Yes | No |
| 5. | What is the name of the insurance company for the other car? | | |

- | | | | |
|----|--|-----|----|
| 6. | Have you given a statement to any insurance company? | Yes | No |
|----|--|-----|----|

DAMAGE TO YOUR VEHICLE

- | | | | |
|----|---|-----|----|
| 1. | Were you the driver of the vehicle you where in? | Yes | No |
| 2. | Was the vehicle towed from the accident scene? | Yes | No |
| 3. | Do you have any photographs of any of the vehicles or the accident scene? | Yes | No |
| 4. | Do you have an estimate to repair your vehicle? | Yes | No |
| 5. | Where is the vehicle located now? | | |

MEDICAL TREATMENT

1. What part of your body did you injure (circle all that apply):

- | | | | |
|-------------|-------------|----------------|-------------|
| Neck | Right Leg | Right Arm | Right Foot |
| Upper Back | Left Leg | Left Arm | Left Foot |
| Middle Back | Right Knee | Right Ankle | Right Hand |
| Lower Back | Left Knee | Left Ankle | Left Hand |
| Headaches | Face | Nose | Eye |
| Ear | Right Elbow | Right Shoulder | Right Wrist |
| Fingers | Left Elbow | Left Shoulder | Left Wrist |

Other injuries? _____

2. Please describe the location of any cuts, bruises or scars:

3. Did you leave the scene of the accident by ambulance? Yes No

4. Please use the rest of this page to list all healthcare providers you have seen **BECAUSE OF THIS ACCIDENT** (including all hospitals, doctors, physical therapist, chiropractors, massage therapist, pain management doctors, psychiatrist, psychologist, counselors, etc):

LOST WAGES

ONLY ANSWER THESE QUESTIONS IF YOU HAVE MISSED WORK BECAUSE OF THE ACCIDENT OR YOU THINK YOU WILL MISS WORK BECAUSE OF THE ACCIDENT!!!

1. Have you lost any time from work due to the accident? Yes No

2. Have you been paid for any time you missed from work? Yes No

3. Where did you work at the time of the accident?

4. What is your title at work?

5. Please describe your job duties at work:

6. Please provide your salary or hourly wage:

7. What days or hours have you missed from work?

8. Please mark all that apply to your job:

- | | | | |
|--------------------|-------------|-----------|-------------|
| Power Tools | Typing | Hammering | Reaching |
| Lifting From Floor | Climbing | Crawling | Kneeling |
| Lifting Overhead | Sitting | Standing | Gripping |
| Manual Labor | Supervising | Bending | Office Work |

Other Work Activities: _____

ADDITIONAL NOTES