THE MILLS LAW FIRM LLP
ATTORNEYS AND COUNSELORS AT LAW

# CLIENT QUESTIONNAIRE

Name:_____

Date: _____

How did you hear about The Mills Law Firm? _____

**Please answer the following questions with as much detail as possible so that we may fully evaluate and investigate the potential merits of your case:**

Address: _____
_____
_____
County: _____
Telephone: (Home)_____
(Work)_____
(Cell)_____
E-Mail: _____
SSN: _____
DOB: _____

If applicable:
Spouse's Name: _____
Spouse's DOB: _____
Spouse's SSN: _____
Date of Marriage: _____

If you did not reside at the address listed above at the time of the accident or incident underlying this potential lawsuit, please indicate the address at which you were residing:

_____
_____
_____

1520 Crescent Road, Suite 100 | Clifton Park, NY 12065-7809
Phone: (518) 373-9900 | Fax: (518) 383-7162
inquire@millslawny.com | www.millslawny.com

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Please identify the name of the treating physician(s), medical provider(s) and/or hospital(s) that you feel are responsible for your claim of malpractice:

Please describe the care and treatment that you feel was improper, who provided it and what it is that your doctor/hospital did or failed to do in treating you:

**Injuries:**

Please list all injuries and disabilities you have sustained because of the subject accident or incident. If you are able, set forth whether you believe that the injuries will be permanent.

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Please set forth the names and addresses of all medical providers (including hospitals, doctors, chiropractors, physical therapists, etc.) with whom you have treated because of the medical malpractice. For each medical provider, please set forth the following:

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

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Address:_____
_____
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_____
_____

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_____
Dates of admission or treatment:_____
_____
_____

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

Were you prescribed any medications as a result of the injuries? Y/N

If yes, list all medications _____

Please list any pharmacy from which you have obtained these medications.

Name of Pharmacy:_____
Address:_____
_____
_____

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Address:_____
_____
_____

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Do you have any appointments scheduled for future medical care? Y/N

If yes, please provided detail as to the date, provider and purpose of the future treatment: _____

_____

Have you ever been treated for a similar injury in the past? Y/N

If so, please set forth these medical providers who have treated you for this type of injury in the past.

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

Name of Provider:_____
Address:_____
_____
Dates of admission or treatment:_____
_____
_____

As a result of the medical malpractice that will form the basis for your lawsuit, please state the lengths of time you have been (if at all):

Totally disabled:_____
Partially disabled:_____
Confined to hospitals:_____
Confined to bed:_____
Confined to house:_____

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**Witnesses:**

Please provide the name, address, and telephone number of any witness to the incident or your medical condition.

Please set forth any statements or admissions that you recall the potential Defendants making, including when and where the statements were made:

Please set forth the name, address, and telephone numbers of any physician that has commented on the care and/or treatment that was rendered to you, including where and when such an opinion was expressed to you:

Please provide the name, address, and telephone numbers of any witnesses who were present for any statements or admissions made by the potential defendants.

**Photographs/Documents:**

Do you have photographs of your injuries? Y/N

Do you have videos of your injuries? Y/N

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Do you have any documents in your possession that you believe will assist in establishing your claim? Y/N

If yes, please describe _____

Have you obtained any of your medical records? Y/N

**Health Insurance:**

Please provide the following information about your medical insurance coverage (including Medicare or Medicaid):

1) Name of Provider:_____
2) Address of Provider:_____
3) ID# (and group policy number, if applicable):_____
4) Amount of co-pay and/or deductible:_____

**Additional Benefits:**

Please provide the following information about any additional benefits which you are receiving (even if you are receiving Medicare or Medicaid):

1) No-Fault Benefits? Y/N
   Insurance Carrier:_____
   Carrier's Addresses:_____
   Policy or Claim No.: _____
   Date of Accident:_____

2) Workers' Comp Benefits? Y/N
   Carrier:_____
   Carrier's Address:_____
   WCB Case No.:_____
   Date of Accident:_____
   Monthly Benefit Receiving:_____

3) Social Security? Y/N
   Beneficiary's SSN:_____
   Monthly Benefits Receiving:_____
   Date Benefits Started:_____

4) Social Security Disability? Y/N
Beneficiary's SSN:_____
Monthly Benefit Receiving:_____
Date Benefits Started:_____

5) Pension and/or Retirement? Y/N
Benefits Received Through:_____
Address:_____
Monthly Benefit:_____
Date of Retirement:_____
Date Benefits Started:_____

**Expenses:**

Please list any and all expenses that you have incurred related to this injury or occurrence. This may include co-pays, mileage, housecleaning services, childcare, home maintenance services, or any service/item that you had to pay for due to injury/disability. Please also include the name and address of anyone you have paid for these services:

_____
_____
_____
_____

**Employment History:**

Please provide the following information for each employer since the date of injury:

Name and Address:_____

Position Held:_____

Hourly, monthly, or yearly wage:_____

Benefits received (ex. Pension, 401K contributions, medical coverage):_____
_____
_____
_____
_____

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Have you lost time from work because of your injury? Y/N

If so, set forth the period of time that you were out of work_____

_____

Set forth the total amount of wages you have lost to date: _____

If there have been other ways in which these injuries have Affected your life (ex. cannot pick up children, garden, walk, drive, etc.), please set forth some "enjoyment of life" issues to give us a better picture of how your claim has affected you and your family:

_____

_____

_____

_____

_____

Have you ever been involved in a prior claim or lawsuit? If so, please describe:_____

_____

_____

_____

Have you ever received any prior settlements due to a personal injury action? If so, please describe:_____

_____

_____

_____

**Client Signature** _____

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