



THE MILLS LAW FIRM^{LLP}
ATTORNEYS AND COUNSELORS AT LAW

CLIENT QUESTIONNAIRE

Name: _____

Date: _____

How did you hear about The Mills Law Firm? _____

Type of Case: MVA | Premises Liability | Labor Law | Product Liability

Other: _____

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:



Accident/Incident Details:

Date of Accident/Incident: _____

Location of Accident/Incident: _____

Did the police respond? Y/N

If yes, which department: _____

Were there any tickets issued? Y/N

If yes, please explain _____

Were you taken by an ambulance from the scene? Y/N

If so, please detail the paramedic or ambulance unit: _____

For motor vehicle cases:

Driver's name: _____

Passenger(s) name(s): _____

Make, model and year of vehicle(s) involved: _____

Please describe how the accident/incident occurred:



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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.

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 Defendants saying, stating specifically when and where the statements were made:

Photographs/Documents:

Do you have photographs of the incident/accident scene? Y/N

Do you have photographs of the injuries? Y/N

Do you have videos of the incident/accident scene? Y/N

Do you have videos of the injuries? Y/N

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

If yes, please describe _____



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Injuries:

Please set forth the names and addresses of all hospitals and medical providers (including chiropractors, physical therapists, psychologists etc.) that have provided medical care to you as a result of the accident or incident.

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: _____

Name of Provider: _____
Address: _____

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: _____

Name of Pharmacy: _____
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 accident or incident 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: _____



Health Insurance:

Please provide the following information about your medical 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 _____