



JZ helps
an injury law firm

1450 Madruga Ave.
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Coral Gables, Florida 33146

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Evaluation Checklist - Negligence

A. Date of Incident _____

The following checklist is a guide to identifying the many issues in a typical personal injury case. If a question is not applicable, write "N/A."

1. Name and Address

A. Full Name _____

B. Current address _____

C. Email _____

D. Home Phone Number: _____

E. Cell Phone: _____

Driver's License Number# _____

If your mail is returned as undeliverable or your telephone service terminated, please provide the name of someone (friend or relative) you believe will always know how to contact you.

F. Name _____ Relationship _____

G. Address _____ Phone No. (____) _____

H. City _____ State & Zip _____

EXPECTATIONS

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Ideally, if things turn out precisely the way you want, what would the outcome be?

Knowing that there are no guarantees, what can you accept?

Please classify your urgency in concluding this matter? (Check One)

- Critical – Personal safety or continuation of business depends on it.
- Very important – severe hardship, personal or financial inconvenience if matter is not resolved quickly.
- Important – Matter interferes with business or personal financial stability.
- Needs to be done, but no immediate hardship in the interim.
- Just thought I'd see if it was worth pursuing, but I'm not counting on anything
- Just wanted to know what my rights are? I'll then let you know after I think about it.

If the matter involves payment to you of money you feel you are owed, how long can you wait before not getting paid? _____

(Days, Weeks, Months, Years)

Are we the first attorneys you have consulted regarding this matter? Yes NO

If No - Why didn't you hire their services? _____

Have you ever been represented by an attorney before? Yes NO

If Yes - Please state the circumstances _____

2. EMPLOYMENT RECORD

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List your employment record as far back as you can remember. Your current and past employment record is important in determining your disability from an occupational viewpoint. Please send us a copy of your most recent resume if you have one.

Current Employer Name: _____

May we contact you there? [] Yes [] No Phone No. (____) _____

Were you employed on the day of the incident? _____

Phone Number: _____

Address: _____

Employed from: _____ to: _____

Job Title: _____

What Type of Work were you doing? _____

Reason for leaving: _____

* * *

Past Employer Name: _____

Address: _____

Employed from: _____ to: _____

Job: _____

Reason for leaving: _____

* * *

Past Employer: _____

Address: _____

Employed from: _____ to: _____

Job: _____

Reason for leaving: _____

* * *

Past Employer: _____

Address: _____

Employed from: _____ to: _____

Job: _____

Reason for leaving: _____

* * *

Past Employer Name: _____

Address: _____

Employed from: _____ to: _____

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Job: _____

Reason for leaving: _____

3. Former Names, Past Addresses, SS #, DOB, Name of Spouses

Have you ever used, or been known by, any name other than the name shown above? If so, list the other names, and state when and why the other names were used.

Please list the addresses where you have lived for the past 10 years:

Address at time of incident _____

Dates Lived _____

Past Address _____

Dates Lived _____

Past Address _____

Dates Lived _____

Past Address _____

Dates Lived _____

Past Address _____

Dates Lived _____

Past Address _____

Dates Lived _____

Your Social Security number: _____

Date of birth _____

Where were you born? _____

Have you ever used any other birth date or birthplace? _____

If so, give details: _____

Are you married? _____

Date of marriage: _____ Place: _____

What is the full name of your spouse? _____

Are you living together now? _____

Have you previously been married? _____

If so, list the names and addresses of prior spouses: _____

Have you ever been divorced or legally separated? _____

If so, from whom, when, and where? _____

4. Eyesight, Hearing

Do wear glasses? _____ Reading only _____

In the last 10 years, have you worn corrective devices for your vision or hearing?

In the last 10 years, have you worn corrective devices for your vision or hearing?

As to corrective devices, who prescribed the device and when were they prescribed?

Name _____ Address _____ Date Prescribed _____

In the last 10 years, have you undergone any procedure to correct your vision or hearing?

As to any corrective procedures, who performed the procedure and the date it was performed.

Name _____ Address _____ Date Performed _____

Please list each time in the last ten years when were your eyes or ears were examined, and list the name of the examiner.

Date Eyes Examined _____ Name of Examiner _____ Address of Examiner _____

Date Ears Examined _____ Name of Examiner _____ Address of Examiner _____

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Were you wearing corrective devices for you vision at the time of the incident? _____

Were you wearing corrective devices for you hearing at the time of the incident? _____

5. Criminal History

You should expect that the claims adjuster will run a criminal history search on you. We have settled many cases even though our clients have past felony or misdemeanor. Please be honest with us so that we can help you!

A. Have you ever been convicted of a crime, other than any juvenile adjudication, which under the law under which you were convicted was punishable by death or imprisonment in excess of 1 year?

If yes, state as to each conviction:

Specific crime _____

Date and place of conviction _____

Do any documents exist wherein this information is referenced? _____

If so:

1. Who wrote them? _____
2. Who has them? _____
3. When were they written? _____
4. What do they say? _____

B. Have you ever been convicted of a crime that involved dishonesty or a false statement regardless of the punishment?

Specific crime _____

Date and place of conviction _____

Do any documents exist wherein this information is referenced? _____

If so:

1. Who wrote them? _____
2. Who has them? _____
3. When were they written? _____

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4. What do they say? _____

6. Injuries At Time of Incident but before Incident

Were you suffering from infirmity, disability, or sickness at the time of the incident described in the complaint? _____

If so, what was the nature of the infirmity, disability, or sickness?

7. ALCOHOL, MEDICATION, AND/OR DRUGS

A. Did you consume any of following in the twelve hours before the incident?

1. Alcohol (Y/N) _____ If yes, please state:

Type of alcohol consumed _____

- a. amount consumed _____
- b. When did you consume it? _____
- c. Where did you consume it? _____

2. Drugs (Y/N) _____ If yes state:

- d. type of drugs consumed _____
- e. amount consumed _____
- f. When did you consume it? _____
- g. Where did you consume it? _____

3. Medication (including prescriptions) (Y/N) _____ If yes state:

- h. type of medications consumed _____
- i. amount consumed _____
- j. When did you consume it? _____
- k. Where did you consume it? _____

8. The Incident

Describe in detail how the incident happened:

Did you take any actions taken by you to prevent the incident? _____.

If yes, what actions did you take to prevent the incident?

9. Other Parties Negligence

Describe what you think the other party did wrong that caused your injuries?

Describe what you think the other party failed to do that caused your injuries?

10. Claimant Charges with Violation

Were you charged with any violation of law (including any regulations or ordinances) arising out of the incident described in the complaint? (If No, skip to question 11)

If yes, what was the nature of the charge? _____

What was the plea or answer? _____

If any, did you enter to the charge? _____

What court or agency heard the charge? _____

Was any written report prepared by anyone regarding this charge? _____

If yes, what is the name and address of the person or entity that prepared the report?

Do you have a copy of the report? _____

Was the testimony at any trial, hearing, or other proceeding on the charge recorded in any manner? _____

If so, what is the name and address of the person who recorded the testimony?

11. Injuries; Body Part; Nature; Effects that are Permanent

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State all injuries known or believed by you to have been received as a result of this accident:

Disability — length of time confined to bed: _____

and thereafter to house: _____

State your present physical condition — scars, disabilities, deformities, discomforts — resulting from the injuries received in this accident:

Activities eliminated or hampered as a result of this injury. List here all the usual activities that you have NOT been able to perform since the accident, such as cutting grass, dancing, etc.:

Are you having any problems with your senses of taste, smell, or hearing? _____

Are you feeling any pain in your neck? _____

Are you suffering with any shoulder pain? _____

Are you experiencing any tingling, numbness or feelings of pins and needles down _____ either
one of your arms? _____ (If the answer is yes, please answer below)

Are you getting a sensation in your right arm or left arm or both? _____ If the
complaint is in both arms, then is it more predominant in your right or your left arm?

Are you feeling the radiation tingling and numbness down into your fingers? _____

(If there is radiation into the fingers, then in which fingers do you feel the sensation? _____)

Is the radiation tingling or numbness that you're feeling constant or intermittent?

Do you feel any pain in either of your elbows? _____

Do you feel any pain in either of your wrists or fingers? _____

Do you feel any back pain?

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What portion of your back? (Lower, Mid/Upper Back ,or neck.)

Are you feeling pain in your hip area? _____

Are you experiencing pain, tingling, numbness, or radiation of pain down either one of your legs?

Are you getting a sensation in your right leg or left leg or both? _____

If you are getting a sensation in both legs, then is it more predominant in your right leg or your left leg?

Are you feeling the radiation tingling and numbness down into your toes? _____

(If there is radiation into your toes then in which toes do you feel the sensation?)

Is the radiation tingling or numbness that you're feeling constant or intermittent?

Are you having any pain in your knees? _____

Are you having any pains in your feet? _____

Did you strike your head? _____

Are you suffering with headaches? _____

Did you suffer a head injury? _____

Are you having any problems with dizziness? _____

Did you injure your jaw? _____

Are you having any pain in the area of your jaw? _____

12. Expenses or Damages (Other than Loss of Income)

(a) Hospitals Amount

(b) Doctors Amount

(c) Nurses and Therapists Amount

(d) Medical Appliances Amount

(e) Drugs and Medicines Amount

(f) Ambulance Amount

(g) Domestic/Household Help Amount

(h) Transportation Expenses Amount

(i) Property Damage Amount

(j) Miscellaneous Expenses Amount

Note: PLEASE KEEP ALL BILLS AND RECEIPTS AND TURN THEM OVER TO YOUR ATTORNEY.

13. Lost income, benefits, earning capacity in past or future

What education have you had, including any special employment training?

Did you lose wages for the periods of time missed from work because of this accident?

If so, state the total loss to date: _____

Have you received any increases or decreases in your pay since the accident?

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If so, explain: _____

If you have changed jobs since the accident, give a summary of your present job, showing name and address of employer, rate of pay, hours, and type of work performed:

Were you employed at the time of the accident? _____

a. If so, state name and address of employer:

b. What was your job title, or what type of work were you doing?

b1. What was your rate of pay? _____

c. Did the job provide or pay for Day Care for your children?

d. How many hours per week were you regularly working immediately before the accident?

e. When were you first employed by the company for which you were working at the time of the accident?

f. Have you remained in the same job since that date?

g. If not, state the reason for the termination of employment:

h. Have you missed any time from work as a result of your injury? If so, list the dates you were unable to work because of your injury:

i. Have you, BEFORE this accident, lost time from work because of an injury?

If so, give details: _____

14. Third Parties Who Paid Benefits (Subrogation)

INSURANCE PLANS AND WORKERS' COMPENSATION

Health Insurance

Name and address of your health insurance company: _____

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Policy number: _____

Have you changed health insurance companies since this incident? _____

Workers' Compensation

Were you injured on the job in this accident? _____

Are you receiving payments at present? _____

If so, explain:

Name and address of the attorneys who are handling the workers' compensation at present:

Government Assistance

Have you applied for or are receiving government assistance in the form of:

Medicaid (Yes or No): _____

Supplemental Security Income (SSI) (Yes or No): _____

Food Stamps (Yes or No): _____

Section 8 HUD housing (Yes or No): _____

Social Security disability: _____

Have you received social security benefits or Medicare benefits as a result of this accident?

Private or Group Disability Benefits

Have you ever applied for or are receiving private or group disability benefits? _____

If Yes, how did you get the disability benefits (e.g. through your employer, through your spouse's employer, through your parent's employer, individual insurance, etc.)?

What is the name and contact information of the company who paid you the private or group disability benefits? _____

Life and Accidental Death & Dismemberment Benefits

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Have you ever applied for or are receiving Life and Accidental Death & Dismemberment Benefits?

If Yes, how did you get the Life and Accidental Death & Dismemberment Benefits (e.g. through your employer, through your spouse's employer, through your parent's employer, individual insurance, etc.)?

What is the name and contact information of the company who paid you the Life and Accidental Death & Dismemberment Benefits?

Long Term Care Benefits

Have you ever applied for or are receiving Long Term Care Benefits? _____

If Yes, how did you get the Long Term Care Benefits (e.g. through your employer, through your spouse's employer, through your parent's employer, individual insurance, etc.)?

What is the name and contact information of the company who paid you the Long Term Care Benefits?

15. Physicians who treated you for injuries from incident

Emergency medical personnel

a. Was an ambulance or paramedics called? _____

b. Who called them? _____

c. How long after the fall did they arrive? _____

d. Did they render medical aid at the site? _____

e. What did they do? _____

e1. Name of the ambulance service or paramedics _____

f. Did they comment on the accident? _____

What did they say? _____

g. Did you tell them what caused the fall? _____

What was said? _____

EMERGENCY HOSPITAL and MEDICAL TREATMENT

A. Were you transported to a hospital? _____

Which one? _____

Address of hospital: _____

What treatment was given? _____

Was a history given? _____

Did you make a statement regarding the accident? _____

What was said? _____

Why admitted:

Date admitted: _____ Date discharged: _____

Name(s) of treating doctor(s) _____

Were you transferred to any hospitals after the first hospital?

If yes, how were you transferred? _____

Name of additional Hospital? _____

Have you been returned to any hospitals since you initial treatment there?

If yes, name of hospital:

Outpatient treatment

List all physicians or other medical care providers seen since hospitalization and list treatment provided:

Name _____ Address _____
Nature of Treatment _____

Date care began: _____ Still under care? _____

Name _____ Address _____
Treatment _____

Date care began: _____ Still under care? _____

Name _____ Address _____
Treatment _____

Date care began: _____ Still under care? _____

Name _____ Address _____
Treatment _____

Date care began: _____ Still under care? _____

Name _____ Address _____
Treatment _____

Date care began: _____ Still under care? _____

Name _____ Address _____
Treatment _____

Date care began: _____ Still under care? _____

All nurses or therapists who have treated you as a result of this accident or incident.

Name: _____

Address: _____

Nature of treatment:

Date care began: _____ Still under care? _____

* * *

Name: _____

Address: _____

Nature of treatment:

Date care began: _____ Still under care? _____

MILITARY BACKGROUND

18. Have you ever been rejected for military service because of physical, mental, or other reasons?

a. If so, explain: _____

b. Have you ever served in the military? If so, state branch of military:

Service Serial No.: _____

Dates of service. From: _____ To: _____

Type of discharge: _____

c. Any service-connected injuries or disabilities? _____

Details: _____

d. Percentage of disability: _____

Present condition of service-connected injury or disability:

Do you receive payments for service-connected injuries or disability?

16. PRIOR MEDICAL TREATMENT, ACCIDENTS AND INJURIES IN PAST 10 YEARS

The failure to mention other past medical treatment, accidents, injuries or can weaken a lawsuit, no matter how minor they may seem. List here every prior incident, whether it resulted in a claim for damages or not, stating the date, place, and nature of the accident, and the extent of your injuries.

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Please include injuries or medical treatment even if you did not make a claim. If you have had no prior accidents or injuries, state "none." If you need additional space, you the last page of this document.

Prior Physical Examinations

List here EVERY physical examination you have had during the last 10 years for employment promotion, insurance, selective service, armed forces, and others, stating the date, name of the doctor, and result, as fully as you can recall.

Date: _____ Place: _____
Doctor's name: _____
Address: _____
Purpose: _____ Result: _____
* * *

Date: _____ Place: _____
Doctor's name: _____
Address: _____
Purpose: _____ Result: _____

Date: _____ Place: _____
Nature of medical treatment, accident or injury _____
Extent of injury: _____
Names and addresses of doctors and hospitals:

* * *

Date: _____ Place: _____
Nature of accident or injury: _____
Extent of injury: _____
Names and addresses of doctors and hospitals:

Date: _____ Place: _____
Nature of medical treatment, accident or injury _____
Extent of injury: _____
Names and addresses of doctors and hospitals:

* * *

Date: _____ Place: _____
Nature of accident or injury: _____
Extent of injury: _____
Names and addresses of doctors and hospitals:

17. OTHER PERSONS WITH KNOWLEDGE OF ISSUES, AND ANY OTHER PEOPLE WHO MAY BE OF ASSISTANCE IN TESTIFYING ABOUT YOUR CASE.

A. At the time of the incident, were you alone? _____

B. Name of any witness _____
Address: _____
Relationship: _____

Sex _____

Approximate age _____ Hair Color _____ Build _____

Was witness wearing uniform? _____

18. STATEMENTS OR REMARKS BY ANY PARTY OTHER THAN YOURSELF CONCERNING ANY ISSUES IN THIS CLAIM

Did witness speak to you? _____

If so, what was said? _____

19. KNOWLEDGE ABOUT, POSSESSION, CUSTODY, OR CONTROL OF PICTURES, VIDEO, ETC.

Has anyone taken photographs or videotapes of your injuries? _____

If so, state the name and address of the person who took them and the person who has possession of them:

Name: _____

Address: _____

Phone: _____

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Email: _____

20. CHILDREN

List the names, addresses, and ages of all your children and your relationship to each.

Name _____

Address _____

Age _____

Relationship _____

Name _____

Address _____

Age _____

Relationship _____

Name _____

Address _____

Age _____

Relationship _____

Name _____

Address _____

Age _____

Relationship _____

Which, if any, of the above children are dependent on you for support?

Name _____

Name _____

ACCIDENTS OR INJURIES AFTER THIS ACCIDENT

If you have had ANY accident or injury SINCE the one for which we are representing you, state concerning each:

Date: _____ Time: _____

Place: _____

How it happened: _____

Were you insured? _____ By whom? _____

Names and dates of medical treatment or hospitalization and names and addresses of treating _____

physicians: _____

Names and dates of medical treatment or hospitalization and names and addresses of treating physicians:

21. BANKRUPTCY

Have you filed for Bankruptcy? _____
Do you plan on filing for Bankruptcy? _____

22. PRIOR LAWSUITS OR CLAIMS

We know there have been many cases damaged beyond repair by a history of other claims and lawsuits that the attorney did not know about. It is NOT the fact that one has had other claims or lawsuits that is important, for one will not be penalized by a court or jury if the claims are reasonable and genuine.

It is the DENIAL of previous claims and lawsuits that damages the case. List every claim you have ever made for personal injury or property damage, and give details. This includes claims under state workers' compensation laws, Railroad Sickness Benefits, and the Longshore and Harbor Workers' Compensation Act. If you have made no claims and filed no lawsuits, state "none."

Date: _____ Nature of claim: _____

Against whom: _____

Suit filed: _____

Result: _____

* * *

Date: _____ Nature of claim: _____

Against whom: _____

Suit filed: _____

Result: _____

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Extra Space

Question #

Answer

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Extra Space

Question #

Answer

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