JZ helps
an injury law firm

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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

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

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: _____
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 _____

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? _____
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

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?
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?

_____

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: _____

_____
Policy number: _____
Have your 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

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? _____

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. 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, POSSESION, 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: _____
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 <u>AFTER</u> THIS ACCIDENT

If you have had ANY accident or injury **<u>SINCE</u>** 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: _____

Extra Space

Question #	Answer

Extra Space

Question #	Answer