Law Offices of George R. Brezina, Jr., P.A.

Confidential Client Questionnaire

Questions marked with an asterisk "*" apply only to motor vehicles accidents

The information, answers represented below and responses provided below are truthful and made to the best of my memory. Executed under penalties of perjury by:

_____

Signature and Date

Thank you for your confidence in selecting **The Law office of Georg R. Brezina, P.A.** to represent you in your personal injury claim. In order to most effectively represent you, we must obtain the following information. Please complete this form as fully as possible. All information provided to this law firm is protected by the attorney-client privilege. We appreciate your effort in completing this form.

1. Last name: _____ First name: _____ MI: _____
2. Age _____ Date of birth: _____ Social Security #: _____
3. Driver's License/ID No.: _____ State _____
4. Telephone Numbers:
   (Home): _____
   (Work): _____
   (Cell): _____
   (Fax): _____
   (E-mail address): _____
5. Home Address:
   Street _____
   Apt #: _____
   City, State & Zip Code: _____

6. Name, Address and Telephone Number of a person (not living with you) to contact in case of and emergency: _____

_____

ACCIDENT INFORMATION

7. Date of Accident: _____

Day of week: _____

Time: _____ AM ____ PM ____

8. Location (Be as specific as possible): _____

_____

9. Describe details of the accident: _____

_____

_____

_____

10. Did you complete an incident report to property owner, manager or anyone else? _____ Yes _____ No

If so, state that person(s) name, address & phone number:_____

_____

_____

11. Do you know if there were any witnesses to the accident?

_____ Yes _____ No

If so, list the names, addresses, and telephone numbers of all witnesses to the accident.

_____

_____

_____

12. Please give us any statement you heard the Defendant make about the incident, or that you understand that he/she may have made.

_____

13. Describe **all** injuries you sustained as a result of the accident: _____

Were any photos taken of your bodily injuries? Yes No If so, name & ph# of person who took the photos & date photos taken:

14. Did an ambulance come to the scene? _____ Yes _____ No

If so, what was the name of the Ambulance/EMS? _____

15. Did you receive treatment at the scene? _____ Yes _____ No

16. Did the ambulance transport you to the emergency room? _____ Yes _____ No

If so, which hospital were you taken to? _____

17. Were x-rays taken at the hospital? _____ Yes _____ No

18. Please list ***ALL*** of the Doctors and any other Medical Facilities you have been to as a result of the accident (include address and telephone number, if known):

a. Name: _____

Address: _____

Telephone Number: _____

b. Name: _____

Address: _____

Telephone Number: _____

c. Name: _____

Address: _____

Telephone Number: _____

d. Name: _____

Address: _____

Telephone Number: _____

e. Name: _____

Address: _____

Telephone Number: _____

EMPLOYMENT INFORMATION

19. Name of your employer at the time of the accident: _____

Employer's Address: _____

20. How long had you worked for this employer prior to the accident? _____

21. Job title at the time of the accident: _____

22. Duties: _____

_____

_____

23. Rate of pay at the time of the accident: _____

24. Have you missed any time from work as a result of the accident? ____ Yes ____ No

If yes, please list the dates and reasons you were unable to work:

Date Reason Unable to Work

_____

_____

25. Did you lose any wages? _____ Yes _____ No

If so, what is the total amount of your lost wages at this time? _____

26. Have you used vacation or sick time to avoid losing wages? _____ Yes _____ No

27. Have you changed jobs since the accident? _____ Yes _____ No

If yes, please list why and the name and the address of your new employer:

_____

_____

INSURANCE INFORMATION

28. Do you know whether the person/business causing your injuries was covered by any type of insurance? _____ Yes _____ No _____ Uncertain

If so, what is the name of the insurance company? _____

29. What is the claim number? _____

30. Have you spoken with anyone from the insurance company? _____ Yes _____ No

31. Did anyone take a recorded statement from you? _____ Yes _____ No

32. Were you covered by any type of **HEALTH INSURANCE** at the time of your accident or at any time since your accident? _____ Yes _____ No

If so, what is the name of the health insurance company? _____

Insurance Policy Number: _____

Type of Coverage: ____ PPO ____ HMO ____ Medicare ____ Medicaid

Telephone number of claims department: _____

LIENS

33. Have you ever made an application to the State of Florida or your County of residence for financial assistance in the payment of rent and/or utilities, etc.? ___ Yes ___ No

If yes, was assistance received? Who provided assistance? Amount provided? _____

_____

34. Have you filed for bankruptcy within the last 7 years? _____ Yes _____ No

If yes, what was the date filed and discharged? _____

Please provide name, and address of attorney, if any. _____

_____

35. Do you have any child support applications? _____ Yes _____ No

If yes, has an Order been issued by any Court? _____

Do any arrearage exist? _____

36. Are you aware of any federal and/or IRS tax liens against you? _____ Yes _____ No

If yes, please explain. _____

_____

SPOUSE INFORMATION

37. Spouse's Full Name: **(at the time of the accident)**: _____

Age: _____ Date of Birth: _____

38. How long have you been married? _____

39. Spouse's Occupation: _____

CHILDREN

40. Do you have any Children? _____ Yes _____ No

If so, please state:

Name	Age	DOB	Living w/ you at time of accident		living w/ you now	
			Y N		Y N	
			Y N		Y N	
			Y N		Y N	
			Y N		Y N	
			Y N		Y N	
			Y N		Y N	

41. Have you **EVER** suffered from any **SIMILAR** pain, injury or condition at **ANYTIME PRIOR** to this accident? _____ Yes _____ No

If so, fully describe: _____

_____

_____

42. Have you **EVER** been treated by any of the following physicians **PRIOR** to your current accident?

Chiropractor: _____ Yes _____ No

Orthopedic Surgeon: _____ Yes _____ No

Neurologist: _____ Yes _____ No

Neurosurgeon: _____ Yes _____ No

Physical Therapist: _____ Yes _____ No

43. Prior to this accident, have you ever made a claim to be compensated for injuries?

_____ Yes _____ No

44. How were you referred to this office?

Attorney _____ Friend/Relative _____

Yellow Pages _____ Other _____

INJURIES AS A RESULT OF PRESENT ACCIDENT

Headaches _____

Jaw pain? R/L _____ Who is your dentist? _____

Ringing/Ear _____ Popping/clicking jaw _____

Painful eating chewy/hard food? _____

Dizziness _____ Nausea _____

Were you knocked ***unconscious*** at scene of accident? _____ Memory loss? _____

Insomnia/Sleeplessness _____

Neck? R/L _____

Shoulders? R/L _____

Wrist pain? R/L _____ Dropping things/numbness/tingling hands R/L _____

Radicular-Arms R/L _____

Numbness/tingling/pain-fingers/arms? R/L _____

Mid back? _____

Chest pain? _____ Abdominal pain? _____

Low back? _____ Pain in hips? R/L _____

Radicular (radiating into legs?) R/L _____

Numbness down legs? R/L _____

Tingling in feet? R/L _____

Knee pain? R/L _____

Ankle pain? R/L _____ Foot pain? R/L _____

Fracture of _____

Cast or sling? _____

Cuts/bruises _____ Stitches _____ Scarring _____

Surgery of _____

Other: _____