Submit Form

SHEP LAW GROUP

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Meridian, ID 83646

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Personal Injury Intake Questionnaire

This confidential information is for our records only. **Please complete fully, sign and date.**

I. CLIENT INFORMATION

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Fax: _____ Email: _____

May we contact you at these phone numbers? _____ If not, please provide alternate telephone number(s) where you may be reached: _____

Employer Name, Address and Phone No.: _____

_____

II. SPOUSE'S INFORMATION (if applicable)

Are you married? Yes ☐ No ☐

If Yes, please provide the following about your Spouse: Name: _____

SSN: _____ Spouse's Employer's Name, Address and Phone No.: _____

_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Fax: _____ Email: _____

III. EMERGENCY CONTACT INFORMATION

Emergency Contact(if other than Spouse): _____ Relation to injured party: _____

Address: _____

Phone Number(s): _____

IV. INJURED PERSON (If different from Client info above)

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer Name, Address and Phone No.: _____

_____

Relation to you: _____

V. GENERAL INFORMATION

Purpose of this appointment: _____

Have you ever had another attorney represent you in this matter? ☐ Yes ☐ No

If YES, please state the name and address of the attorney: _____

_____

Was the cause of the injury investigated by law enforcement: ☐ Yes ☐ No

If YES, what law enforcement agency conducted the investigation: _____

VI. ACCIDENT INFORMATION

Date of injury: _____

How was injury sustained (i.e., motor vehicle accident, slip and fall, etc.): _____

_____

Location where accident occurred: _____

Type of injury(ies) sustained: _____

_____

_____

_____

Please describe how the injury(ies) have affected the injured person's lifestyle. For example, if the injured person was a golfer, how have the injuries affected that, etc. (Be as detailed as possible) _____

_____

_____

_____

_____

_____

VII. MEDICAL TREATMENT

Did you seek medical treatment? ☐ Yes ☐ No

If Yes, when was medical treatment first sought? _____

If No, why was medical treatment not sought? _____

Medical Service Provider and Treating Physician name(s), address(es) and telephone number(s): _____

_____

_____

_____

_____

_____

VIII. INCOME:

Have you missed any work due to the accident? ☐ Yes ☐ No If yes, please complete the following:

Pay rate: $_____ (hourly or salary)

Hours injured person works per week: _____

List the days and hours of missed work related to this accident: _____

_____

_____

NOTE: We request that you provide us with the most recent paystub at your earliest convenience.

IX. INSURANCE INFORMATION

What is the name, address and policy number for the auto insurance company for the vehicle involved in the accident (if applicable)? _____

_____

Does the injured person have medical coverage, including Medicare, Medicaid or auto policy? ☐ Yes ☐ No

If your answer is Yes, please provide a copy of the injured person's insurance card and provide the following: Name(s), address(es), telephone number(s) and policy number(s), (i.e. medical, auto, home, other) for each and every insurance carrier who has paid or will pay benefits for the injured person for treatment related to the injury: _____

_____

_____

_____

X. RESPONSIBLE PARTY INFORMATION

Name and address (if known) of person who caused the injury and insurance information (if known): _____

_____

_____

_____

XI. OTHER LOSSES

Have you sustained any other damage, loss or other harm from the accident that you have not already disclosed? If so, please describe in detail: _____

_____

_____

_____

XII. OTHER RELEVANT INFORMATION

Please provide names of other witnesses, evidence or information that might be helpful in pursuing this claim:

_____

_____

How did you hear about Shep Law Group? _____

Referred by: _____

Radio: _____ *Google:* _____ *Thumb Tack:* _____ *Bing:* _____ *Other:* _____

ACKNOWLEDGEMENT OF PAYMENT OBLIGATION

I understand that I am responsible for payment of all costs incurred and fees earned for which I am seeking counsel. I understand that I will be billed on a monthly basis and my account must be paid in full each month unless other arrangements are made. If I have more than one matter with the firm, I hereby consent and direct any payment that I make be applied to the oldest account first.

I understand that, if a retainer is required, I must pay the retainer in full before any work on my case will commence. If a retainer is paid, such retainer will be applied to my monthly bill until depleted. I further understand that once my original retainer is depleted, an additional retainer may be required of me and that work on my case may be suspended until such time as the additional retainer is paid. I also understand that once the retainer is depleted, I am responsible to pay each bill received from Shep Law Group upon receipt.

I understand that if I do not comply with payment requirements, the handling attorney may withdraw from my case and my account may be sent to a billing/collection agency, wherein additional costs may be incurred.

Additional terms:_____

_____

_____

_____

Signature: _____ Date: _____

For Shep Law Group Official Use Only:

Matter Number:	**Matter Description:**
Originating Attorney	**Responsible Attorney**
Billing Type (Circle One): **( ) Hourly ( ) Flat Fee ( ) Contingency**	**Retainer Amount Quoted:**
Retainer Received: ( ) Y ( ) N	**Payment Terms:**