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CINOCCA LAW

PERSONAL INJURY CLAIMANTS

POTENTIAL NEW CLIENT INTAKE WORKSHEET
SUBJECT TO WORK PRODUCT PRIVILEGE

INTAKE QUESTIONNAIRE

Life for an injury victim often times becomes much more difficult after the injury. Not only does the victim suffer physically and mentally, but now the victim or a representative must typically deal with government agencies, doctors, insurance companies and possibly attorneys. Each will require the victim or a representative to provide them with documentation. If you are the person providing the documentation, filling in the form below will prepare you for most of the questions these individuals need answered. Please complete all information as thoroughly as possible and update it, as information may become available to you. Expect in Litigation to see these questions asked of you and more, in a variety of ways numerous times. This will prepare you and your attorney for your case in Court or in other negotiations.

Your Name & Injured Party Name: _____
Are you completing this form for your injuries or those of another? _____
Name of Injured Party: _____
Your Relationship to Injured Party: _____
Your Date of Birth: ____/____/____
Your Social Security No.: _____-____-_____

If you are completing this form for more than one person injured as a result of the same accident, please complete one form for each person.

Your Address: _____
_____
_____
Length of Time there: _____

Prior Address: _____ Time there: _____

Best method to reach you: _____
Best times to reach you: _____

Mobile Phone: (_____) _____-_____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Best Confidential E-mail Address: _____
Other Email: _____

DATE OF ACCIDENT RESULTING IN INJURY: ___/___/___

Negligence has a two year statute of limitations from this date to file a claim of record or be forever barred. You are not a client until an engagement agreement is executed by both of us. You are responsible for meeting any filing deadlines at this time. Please initial here you understand this and at present you are responsible for the timely filing of your claim: ***INITIAL:*** _____

DATE OF FIRST TREATMENT: ___/____/_____
Who first treated you related to the accident? _____
When was this? _____
What was the treatment and injury? _____

LOCATION OF ACCIDENT: _____
STATE: _____ COUNTY: _____ CITY: _____

YOUR RESIDENCE AT THE TIME OF THE ACCIDENT: _____
STATE: _____ COUNTY: _____ CITY: _____

YOUR RESIDENCE NOW: _____ _____
STATE: _____ COUNTY: _____ CITY: _____

Are you: Married: ____ Single: ____ Divorced: ____ Number of children: ____
If married, spouse's name: _____

How did the accident occur? _____
_____
_____
_____
_____

What injuries were sustained by you? _____
_____
_____
_____
_____

Check any & all body parts affected by the accident: □Head □ Neck □Ears □Eyes □Nose □Face □Hair □Mouth □Jaw □Teeth □Tongue □ Mouth □ Taste □ Throat □ Smell □ Hearing □ Sight □ Shoulders □ Back □Upper Back □ Lower Back □ Hands □ Arms □ Wrists □ Fingers □ Hands □ Chest □ Sternum □ Torso □ Hips □ Bottom □ Legs □ Elbows □ Knees □ Thighs □ Ankles □ Feet □ Toes □ Mental □ Calves □ Mental □ Other _____ □ Other _____ □ Other _____ □ Other _____ □ Other _____

Check all that may apply:
□ Defective product
□ Recall
□ Auto Accident
□ Dog Bite
□ Boating or other water related accident: Describe: _____
□ Trucking Accident
□ Slip or trip and fall
□ Corporate Fault (negligent party was on the job, driving a commercial carrier, or a company was somehow at fault or contributed to causing death) Who? _____ How? _____

_____

□ Government Fault (negligent party was on the job, driving a government vehicle, or a governmental entity was somehow at fault or contributed to causing death) Which Government entity? _____ How? _____

_____

□ Other ---Please Describe: _____
_____
_____

Are you active on social media? **YES/NO** (circle)
Do you have any social media accounts? **YES/NO** (circle)
Please identify your handle for any and all social media accounts. _____
_____
_____
_____

Please list two emergency contacts should we be unable to contact you:

Name: _____	Name: _____
Address: _____	Address: _____
City State ZIP: _____	City State ZIP: _____
Email: _____	Email: _____
Phone: _____	Phone: _____

LIABILITY

Who do you think is liable for the accident? _____ Why: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____ Name: _____ Name: _____
Address: _____ Address: _____ Address: _____

City State ZIP: _____ City State ZIP: _____ City State Zip: _____
Email: _____ Email: _____ _____ Email: _____
Phone: _____Phone: _____ Phone: _____
DOB/Age: _____ DOB/AGE:_____ DOB/AGE:_____

Please attach additional sheets, if necessary.

What facts known to you support your opinion of why each of the persons or companies listed by you should be held be liable? _____

What facts unknown to you affecting liability would you like to know more about? _____

Was a vehicle, watercraft or other product involved in the accident? _____
Please explain: _____

WHERE IS IT NOW? _____
HOW CAN WE GET IT, IF NECESSARY, OR FIND OUT WHERE IT IS, IF YOU DO NOT KNOW?

Is there a product recall? _____

List the names, addresses, and phone numbers of any possible witnesses in your case, not already listed on the Accident Report, if you have provided that already.

YOUR INJURIES AND DAMAGES

Describe your injuries here: _____
_____
_____
_____
_____

List all doctors and other health care providers who treated your injuries, including their names, addresses, and telephone numbers. Include the dates of treatment and any pre-existing issues physical and mental issues related and how they were exacerbated. Please identify physicians and their associated groups, hospitals, emergency rooms, ambulances, radiologists, laboratories, pharmacies, mental health care professionals, and any other type of licensed professional from whom you may have received related treatment.

Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Dates of Treatments: _____ _____
Describe your treatment by each and how it helped. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Which area of your body did each of the above providers treat? _____/_____
Describe any preexisting conditions to those areas: _____
_____
_____
_____

Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____

Email: _____ Email: _____
Phone: _____ Phone: _____
Dates of Treatments: _____ _____
Describe your treatment by each and how it helped. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Which area of your body did each of the above providers treat? _____/_____
Describe any preexisting conditions to those areas: _____
_____
_____
_____

Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Dates of Treatments: _____ _____
Describe your treatment by each and how it helped. _____
_____
_____
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_____
_____
_____
Which area of your body did each of the above providers treat? _____/_____
Describe any preexisting conditions to those areas: _____
_____
_____
_____

Attach additional pages as needed for more health care providers.

List all doctors and other health care providers who have treated you for injuries similar or in the same areas before the accident.

Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Dates of Treatments: _____ _____
Describe Similar Body Areas and Treatments: _____

Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Name: _____ Name: _____
Address: _____ Address: _____
City State ZIP: _____ City State ZIP: _____
Email: _____ Email: _____
Phone: _____ Phone: _____
Dates of Treatments: _____ _____
Describe Similar Body Areas and Treatments: _____

Are you claiming any future medical or mental health bills related to your claims? _____: If so, please explain what that is and the likely cost. Show how you computed said cost. _____

When was the last day of your treatment? _____ If treatment is ongoing, what is your expected course of future treatment? _____

Are you in pain? If so, describe. _____

Describe any other ways in which your life has changed as a result of your physical injuries. (For example, changes in your life due to physical injuries like you are no longer able to engage in athletic activities, your appearance has changed, you cannot care for your children, etc.) _____

Describe any other ways in which your life has changed as a result of your mental injuries. (For example, changes in your life due to emotional trauma, loss of consortium, pain, grief that may affect your day to day major life activities like sleep, and how those changes have affected your life, your appearance has changed, you cannot care for your children, etc.) _____

If married, has your spouse experienced any losses as a result of your injury? If so, please Describe: _____

Do you wish to proceed with a loss of consortium claim? **YES/NO** (circle) If so, describe your loss of consortium claim in a way you might describe in detail to a jury. Attach additional pages, if necessary: _____

_____
_____
_____
_____

Do you wish to proceed with a claim for emotional distress? **YES/NO** (circle) If so, have you had any prior mental health care treatment? **YES/NO** (circle) Are you willing to answer highly personal and sensitive questions about your past? **YES/NO** (circle) If so, describe your mental grief and suffering in a way you might tell a jury. Attach additional pages, if necessary: _____
_____
_____
_____
_____

LOST INCOME/WAGES

Do you wish to assert a claim for lost wages? **YES/NO** (circle)
Do you wish to assert a claim for lost income from sources other than wages? **YES/NO** (circle)
If your answer to both questions is no, please continue to the next section.

Have you lost income as a result of your injuries? Check: Yes _____ Amount $_____ or No _____
Income before injury $_____ per _____
Income after injury $_____ per _____
Employer _____
Position _____
Employer's address _____
_____
_____
Employer's telephone number (_____) _____-_____
Are you currently working? Yes ___ No ___ Expect to return to work on ___/___/___
Will not return to work ____

Were you working at the time of the accident? **YES/NO** (circle) If so, please describe your job or other income producing activities affected: _____
_____
_____
_____

How much did you earn? _____

How was your income affected by your injuries from this accident? _____
_____
_____
_____

How do you calculate your lost income from your injuries related to the accident? _____
_____
_____

Please describe your job history, including titles and rates of pay:_____

Would there be a noticeable difference between the income reflected on your tax return for the year you were injured compared to prior years related to your injuries from the accident? **YES/NO** (circle) Please explain how you think this could help or harm your claim for lost income: _____

INSURANCE AND SUBROGATION

Do you have Medicaid or Medicare? **YES/NO** (circle)
If so, you must attach a copy front and back of your cards. They will likely require reimbursement for any out-of-pocket payments and must be notified of your claims pursued.

Do you have other health insurance used for your treatments? **YES/NO** (circle)
If so, you must attach a copy front and back. They will likely require reimbursement for any out-of-pocket payments and must be notified of your claims pursued.

Have you received any itemized or other billing statements? **YES/NO** (circle)
If you have them, please produce them. If you receive more in the mail and we represent you, you must send us copies. Initial here you understand this**: INITIAL: _____**
If your matter involves a vehicle accident, do you or any other members of your household have automobile insurance: **YES/NO** (circle)
If so, please provide a copy of your insurance.

Do you have any other insurance policies in effect that may provide you with any coverage for the incident in question? **YES/NO** (circle)
If so, please explain. _____

List the names, addresses, and telephone numbers of all insurance companies that may be involved which you have not previously identified, if known: (including, as applicable, other people's automobile insurer, disability insurer, homeowner's insurer, etc.). _____

MISCELLANEOUS

Have you previously consulted an attorney regarding your case? **YES/NO** (circle)

If yes, provide the attorney's name(s), the firm name(s), the address(es), and the telephone number(s).

Is your relationship with the attorney ongoing? **YES/NO** (circle)

Has an attorney declined to represent you in this matter? **YES/NO** (circle) If yes, why? _____

Do any prior attorneys have liens in your case? _____

If so, please describe and Identify the attorney with said lien: _____

Can you request and obtain a lien release and attach it hereto? **YES/NO** (circle)

Please explain the status if you are unable to attach a letter from that firm releasing any lien it has. _____

Please circle any of the following which you may have had or done and explain:

□ On SSI □ Medicare □ Medicaid □ Bankruptcy □ Divorce □ Arrests □ Convictions □ Drug Use □ Alcohol Use □ Smoking □ Marijuana. Prescriptions - legal or illegal. □ Handicaps □ Disabilities □ Mental Issues □ Inability to Understand □ Criminal Behaviors □ Reckless Behavior □ Fighting □ Violence □ Poor Relationships □ History of Litigation/Claims □ Limitations on Normal Life Expectancy □ Long term illnesses or conditions □ Negative Issues a private investigator for the Defendant might find out? _____

Please explain any limitations or disabilities or other conditions you have that could affect your ability to understand, travel to Oklahoma for depositions or trial, acquire notarized verifications and forms, respond promptly to emails or texts, scan, acquire documentation, transmit documents via text, email or mail, provide detailed descriptions and explanations, or perform other duties a client would have? _____

What do you hope to find out as a result of our services? _____

What compensation do you hope to receive as a result of our services? _____

Is there anything else you would like for us to know or be aware? _____

Questions you have about your case: _____

By signing this form, you acknowledge as of the date signed, you have provided all information known to you and agree to update the information provided as it becomes available. You understand that this does not create an attorney client relationship, and that such relationship is only created after the execution by both parties of an Engagement Agreement. By signing this agreement, you acknowledge and understand that said attorney has not agreed to file your case, and that you and you alone are responsible for meeting any and all deadlines on your case for filing or you may forever barred therefrom. If you have retained prior attorney(s) on this case, you need to acquire a waiver of any lien interest they may have or a statement of that lien amount from them for our review and consideration before we take your case.

AGREED BY:

X_____
NAME:_____
Address: _____
City State Zip: _____
Email: _____
DOB: _____
SSN: _____
DL NO.: _____ State: _____ Exp: _____

RETURN YOUR COMPLETED FORM TO:

Tcinocca@cinoccalaw.com with Your name in the Re Clause and the words “PNC Personal Injury”

You may also mail your completed form to us at:
Tracy A. Cinocca, P.C.
10026A S. Mingo Rd, #238
Tulsa, OK 74133

If you would like a free consultation, please state the time and method that would serve you best: _____
_____
_____
_____