Client Questionnaire (Medical Malpractice)

Name: _____

Date: _____

How did you hear about Girvin & Ferlazzo, P.C.?_____

Please answer the following questions with as much detail as possible so that we may fully evaluate and investigate the potential merits of your case:

Address:	_____	If applicable:
	_____	Spouse's Name:_____
	_____	Spouse's DOB:_____
County:	_____	Spouse's SSN:_____
Telephone:	(Home) _____	Date of Marriage:_____
	(Work) _____	
	(Cell) _____	
E-Mail:	_____	
SSN:	_____	
DOB:	_____	

If you did not reside at the address listed above at the time of the incident underlying this potential lawsuit, please indicate the address at which you were residing:

_____

_____

_____

MALPRACTICE

Please identify the name of the treating physician(s), medical provider(s), and/or hospital(s) that you feel are responsible for your claim of malpractice:

_____

_____

_____

Please describe the care and treatment that you feel was improper, who provided it, and what it is that your doctor/hospital did or failed to do in treating you:

_____

_____

_____

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_____

INJURIES

Please list all injuries and disabilities you have sustained because of the above incident. If you are able, set forth whether you believe that the injuries will be permanent.

_____

_____

_____

_____

_____

_____

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_____

_____

MEDICAL TREATMENT

Please set forth the names and addresses of all medical providers (including hospitals, doctors, chiropractors, physical therapists, etc.) with whom you have treated because of the medical malpractice. For each medical provider, please set forth the following:

1. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
2. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
3. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
4. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
5. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____

Were you prescribed any medications as a result of the injuries? Y / N

If yes, list all medications _____

Please list any pharmacy from which you have obtained these medications.

1. Name of Pharmacy: _____

   Address: _____
2. Name of Pharmacy: _____

   Address: _____

Do you have any appointments scheduled for future medical care? Y / N

If yes, please provide detail as to the date, provider, and purpose of the future treatment:

_____

_____

Have you ever been treated for a similar injury or condition in the past? Y / N

If yes, please set forth these medical providers who have treated you for this type of injury in the past.

1. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
2. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
3. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____
4. Name of Provider: _____

   Address: _____

   Dates of admission or treatment: _____

As a result of the medical malpractice that will form the basis of your lawsuit, please state the lengths of time you have been (if at all):

Totally disabled: _____

Partially disabled: _____

Confined to hospitals: _____

Confined to bed: _____

Confined to house: _____

WITNESSES/STATEMENTS

Please provide the name, address, and telephone number of any witness to the incident or your resulting medical condition.

_____

_____

_____

_____

Please set forth any statements or admissions that you recall the potential Defendant(s) making, including when and where the statement were made:

_____

_____

_____

_____

Please set forth the name, address, and telephone numbers of any physician that has commented on the care and/or treatment that was rendered to you, including where and when such an opinion was expressed to you:

_____

_____

_____

_____

Please provide the name, address, and telephone numbers of any witnesses who were present for any statements or admissions made by the potential defendants.

_____

_____

_____

_____

PHOTOGRAPHS/DOCUMENTS

Do you have photographs of the incident/accident scene? Y / N

Do you have photographs of the injuries? Y / N

Do you have videos of the incident/accident scene? Y / N

Do you have videos of the injuries? Y / N

Do you have any documents or items that may assist in establishing your claim? Y / N

If yes, please describe _____

HEALTH INSURANCE

Do you receive or are you eligible to receive Medicare or Medicaid benefits? Y / N

Please list all medical insurance providers (including Medicare or Medicaid):

1. Name of Provider: _____
   Address of Provider: _____
   ID# (and group policy number, if applicable): _____
   Amount of co-pay and/or deductible: _____
2. Name of Provider: _____
   Address of Provider: _____
   ID# (and group policy number, if applicable): _____
   Amount of co-pay and/or deductible: _____

ADDITIONAL BENEFITS

Please provide the following information about any additional benefits which you are receiving (even if you are receiving Medicare or Medicaid):

1. **No-fault Benefits** (motor vehicle accidents only)? Y/N
   Insurance Carrier: _____
   Carrier's Addresses: _____
   Policy or Claim No.: _____
   Date of Accident: _____

2. **Workers' Compensation Benefits**? Y/N

   Carrier: _____

   WCB Case No.: _____

   Date of Accident: _____

   Monthly Benefit Receiving: _____

3. **Social Security**? Y/N

   Beneficiary's SSN: _____

   Monthly Benefits Receiving: _____

   Date Benefits Started: _____

4. **Social Security Disability**? Y/N

   Beneficiary's SSN: _____

   Monthly Benefits Receiving: _____

   Date Benefits Started: _____

5. **Pension and/or Retirement**? Y/N

   Benefits Received Through: _____

   Address: _____

   Monthly Benefit: _____

   Date of Retirement: _____

   Date Benefits Started: _____

EXPENSES

Please list all expenses that you have incurred related to this injury or occurrence. This may include co-pays, mileage, housecleaning services, childcare, home maintenance services, or any service/item that you had to pay for due to injury/disability. Please also include the name and address of anyone you have paid for these services:

_____

_____

_____

_____

EMPLOYMENT HISTORY

Please provide the following information for each employer as of the date of injury:

Name and address: _____

Position/title: _____

Length of time employed prior to accident: _____

Hourly, monthly, or yearly wage: _____

Hours/days worked per week: _____

Benefits received (ex. Pension, 401K contributions, medical coverage): _____

_____

_____

Have you lost time from work because of your injury? Y / N

If so, set forth the period of time that you were out of work: _____

_____

Set forth the total amount of wages you have lost to date: _____

LIMITATIONS

If there have been other ways in which these injuries have affected your life (ex. cannot pick up children, garden, walk, drive, cook, etc.), please set forth as many "enjoyment of life" items and physical limitations to illustrate how your claim has affected you and your family:

_____

_____

_____

_____

_____

_____

_____

_____

BACKGROUND

Have you ever been involved in a prior claim or lawsuit? Y/N

If yes, please explain: _____

_____

_____

_____

Have you ever received any settlements due to a personal injury action? Y/N

If yes, please explain: _____

_____

_____

_____

Have you ever been convicted of a crime or declared bankruptcy? Y/N

If yes, please explain: _____

_____

_____

Do you have a Facebook, MySpace, Twitter, YouTube, or other social media account? Y/N

If so please specify: _____

Client Signature**:** _____ Date: _____

Client Signature**:** _____ Date: _____