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## Medical Malpractice Client Interview Form

PLEASE TAKE YOUR TIME IN COMPLETING THIS QUESTIONNAIRE. IT IS VERY IMPORTANT TO YOUR CASE THAT THIS INFORMATION IS AS THOROUGH AND ACCURATE AS POSSIBLE.

DATE OF INCIDENT: \_\_\_\_\_ TIME OF INCIDENT: \_\_\_\_\_

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ SPOUSE/PARTNER: \_\_\_\_\_

CITY, STATE, ZIP CODE: \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_ AGE: \_\_\_\_\_

CELL PHONE#: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

### MEDICAL MALPRACTICE INFORMATION

WHAT IS THE IDENTITY OF THE DOCTOR AND/OR HOSPITAL IN QUESTION? \_\_\_\_\_

WHEN DID YOU BEGIN THE MEDICAL TREATMENT IN QUESTION? \_\_\_\_\_

WHEN DID THE MEDICAL TREATMENT IN QUESTION END? \_\_\_\_\_

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WHAT OCCURRED THAT LEADS YOU TO BELIEVE A HEALTH CARE PROFESSIONAL CAUSED YOU HARM?\_\_\_\_\_

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HAS ANY HEALTH CARE PROFESSIONAL APOLOGIZED FOR THE RESULTS OF YOUR CARE?\_\_\_\_\_

HAS ANYONE TOLD YOU THAT THE MEDICAL CARE YOU RECEIVED CAUSED YOU AN INJURY?\_\_\_\_\_

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DID YOU SIGN ANY DOCUMENTS ACKNOWLEDGING YOU WERE AWARE OF THE RISKS OF TREATMENT?\_\_\_\_\_

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DID YOU SIGN AN ARBITRATION AGREEMENT PRIOR TO COMMENCING THE MEDICAL CARE?\_\_\_\_\_

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DID YOU HAVE A PRE-EXISTING RELATIONSHIP WITH THE DOCTOR IN QUESTION?

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WAS THE PHYSICIAN IN QUESTION ASSIGNED TO YOU BY A HOSPITAL?\_\_\_\_\_

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WHY DID YOU GO TO THE DOCTOR/HOSPITAL-EXPLAINED WHAT HAPPENED?\_\_\_\_\_

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WHAT IS THE CURRENT STATUS OF THAT CONDITION?\_\_\_\_\_

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WHAT TREATMENT DID YOU RECEIVE?\_\_\_\_\_

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WHAT WERE THE RESULTS OF THAT TREATMENT?\_\_\_\_\_

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\_\_\_\_\_

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE/WHY?\_\_\_\_\_

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WHAT IS YOUR DIAGNOSIS?\_\_\_\_\_

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WHAT IS YOUR PROGNOSIS? \_\_\_\_\_