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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.

### Medical Malpractice Client Interview Form

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? \_\_\_\_\_

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? \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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