MDK KAPLAN LAW, LLC.

Matthew D. Kaplan ATTORNEY AT LAW

KOIN Center, Suite 1111
222 SW Columbia Street
Portland, OR 97201
Phone: 503-226-3844
Fax: 503-943-6670
www.MDKAPLANLAW.COM
matthew@mdkaplanlaw.com

Personal Injury Case Information

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.

INFORMATION ABOUT YOU, THE CLIENT

How Did You Hear About Our Office (Please check one)? Internet:__ Referral:__ Other:_____

Name:_____ Email Address:_____

Street Address:_____

City, State, Zip Code:_____

Cell Phone #:_____Other Phone #:_____

Driver's License # and State:_____ SSN:_____

Date of Birth:_____ If Married on Date of Accident, Name of Spouse:_____

Who else lives in your household: _____

If you, the client, are a minor or living with parent(s):

Mother's Name:_____ Phone #:_____

Father's Name:_____ Phone #:_____

Have you ever filed for bankruptcy? ___ Yes ___ No If so, year it was discharged _____

Do you have any criminal convictions? ___ Yes ___ No If so, for what _____

INFORMATION ABOUT THE VEHICLE YOU WERE IN

If You Are Not the Owner, the Owner's Name:_____

Description Of Vehicle You Were In:_____

License Plate Number and State:_____

Were you: __ the Driver? __ a Passenger?

Were there any other passengers? _____

Owner's Insurance Company:_____

Adjuster(s) Name(s):_____

Adjuster(s) Phone #:_____ Claim # (If Known)_____

Your Insurance Company (if different):_____

WA Clients Only: Do you have Personal Injury Protection (PIP) on your policy: __ Yes __ No

Estimated Damage to your Vehicle: $_____

Has the Property Damage claim been resolved? __ Yes __ No

Have you taken any photographs of the vehicle damage? __ Yes __ No

If any content of the vehicle was damaged, please describe: _____

_____

Have you spoken to an Insurance Adjuster about the accident? __ Yes __ No

Which Insurance Company? _____

Was the statement recorded? __ Yes __ No

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YOUR HEALTH INSURANCE INFORMATION

Your Health Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

Group No.: _____ ID No.: _____

Are you, or will you become, eligible for Medicare within the next 2 years? __ Yes __ No

INFORMATION FOR THE AT-FAULT DRIVER

Registered Owner's Name: _____

Driver's Name (if different): _____

Street Address: _____

City, State, Zip Code: _____

Cell Phone #: _____ Other Phone #: _____

Driver's License # and State: _____ Vehicle License # and State: _____

Driver's Insurance Company: _____

Adjuster(s) Name(s): _____

Adjuster(s) Phone #: _____ Claim # (If Known) _____

Were there any Passengers (names and phone number): _____

_____

Did you take any photographs of this vehicle? __ Yes __ No

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ACCIDENT INFORMATION

Date of Accident:_____ Time of Day:_____ __ a.m. __ p.m.

Location of Accident (City and County):_____

Street and Nearest Cross Street: _____

Weather and Light Conditions:_____

Road Conditions:_____

Posted Speed Limit:_____

In the space below, please diagram the accident scene. Identify your car and all other cars involved in the accident. Please indicate the direction of travel, street names and/or landmarks.

Description of What Happened:_____

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Were you wearing a seatbelt: ___ Yes ___ No Did airbags deploy: ___ Yes ___ No

Did any part of your body hit anything inside the vehicle: ___ Yes ___ No

Were you working at the time of the crash: ___ Yes ___ No

Were you aware of the pending crash: ___ Yes ___ No

Were you stopped, slowing down, or speeding up at the time of impact: _____

If your vehicle was towed, name of tow company:_____

If an ambulance was at the scene, name of the ambulance company:_____

Was a law enforcement agency at the scene (OSP, city police, sheriff): _____

If anybody was cited, who and for what: _____

Have you filed a DMV accident report? ___ Yes ___ No

Did you make any statement to anyone at the scene of the accident? If so, to whom and what did you say: _____

_____

Did the other driver make any statement in your hearing? If so, to whom and what was said: _____

_____

_____

List any independent witnesses (not travelling in either vehicle) and their telephone numbers:

1._____

2._____

3._____

4._____

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WAGE LOSS

Name of Employer:_____

Company Address:_____

Contact Person Title and Name:_____Phone No. _____

Your Job title: _____

Description of Job Duties: _____

_____

Hours normally worked:_____ __ per week __ per month

Hourly rate: $_____ Salaried rate: $_____ __ per week __ per month

Dates unable to work due to accident:_____

Total Income Lost due to accident:_____

INJURIES
Check those that apply

___ Headaches ___ Dizziness ___ Nausea

___ Ringing in Ears ___ Blurred Vision ___ Loss of Memory

___ Jaw Pain ___ Clicking in Jaw ___ Eating/Chewing Difficulty

___ Neck Pain ___ Shoulder Pain L or R ___ Pain in Arm/Wrist/Hand L or R

___ Back Pain ___ Hip Pain L or R ___ Pain in Leg/Knee/Ankle L or R

___ Numbness If so, where? _____

Any Other Injuries:_____

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EMOTIONAL SYMPTOMS
Check those that apply

___ Flash-backs ___ Panic Attacks ___ Crying Spells

___ Anxiety ___ Irritability ___ Depression

IMPAIRED ACTIVITIES
Check those that apply

___ Aerobic Exercise ___ Sports ___ Yoga

___ Jogging/Running ___ Hiking ___ Bicycling

___ Skiing/Snowboarding ___ Golf ___ Tennis

___ Weight lifting ___ Sailing ___ Karate

Other (Please Describe)_____

_____

DAILY ACTIVITIES
Check those that apply

___ Dressing ___ Bathing ___ Brushing teeth

___ Bending ___ Lifting ___ Stretching

___ Sexual Relations ___ Playing with children ___ Gardening/Yard Work

___ Ironing ___ House cleaning ___ Shopping

___ Sleeping ___ Standing ___ Sitting

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PREVIOUS INJURIES

List all previous injuries (including on the job injuries) and who you treated with:

Date Injury Physician/Facility

_____

_____

_____

_____

PHYSICIANS & MEDICAL FACILITIES

Please list the physicians and/or medical facilities, with telephone numbers, with whom you have treated for injuries from this accident:

_____

_____

_____

_____

_____

PLEASE PROVIDE ANY PHOTOGRAPHS THAT EXIST OF YOUR DAMAGED VEHICLE, THE SCENE OF THE ACCIDENT, AND ANY VISIBLE INJURIES. PLEASE PROVIDE A COPY OF ANY REPAIR ESTIMATES TO YOUR VEHICLE. KEEP AND SEND COPIES OF ALL MEDICAL BILLINGS YOU RECEIVE AND KEEP TRACK OF THE DAYS YOU MISS FROM WORK AS A RESULT OF THIS ACCIDENT.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR TREATMENT, THE SETTLEMENT PROCESS, OR ANY OTHER ASPECT OF YOUR CASE, PLEASE FEEL FREE TO CALL OR EMAIL US.

THANK YOU.

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