

Berkowitz Law Group

INITIAL CONTACT SHEET

Referral Source: _____
Currently Rep'd by Atty? _____

DATE: _____
Date of Accident: _____

ACTION: D/C Accept; O/C set for ____ / ____ / ____ @ ____ m.
 Refer to _____

ACCIDENT: MVA MVA/DUI MVA/Ped. MVA/MC
Drivers License # - _____ e-mail - _____

NAME: _____ minor male female

Years in Florida ____	HM PHN: _____	WK PHN: _____	CELL PHN: _____
	ST: _____		Apt. _____
	CITY: _____		STATE/ZIP: _____
	D/B: _____	SSN: _____	
Alternate Contact:	<input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> friend		
	PHN/ADDRS: _____		

INSURANCE:	Type: <input type="checkbox"/> auto/PIP/UM <input type="checkbox"/> health	Company: _____	Pol. No. _____
	Ins'd: _____	Coverage: _____	Clm. No. _____
INSURANCE:	Type: <input type="checkbox"/> auto/PIP/UM <input type="checkbox"/> health	Company: _____	Grp. No. _____
	Ins'd: _____	Coverage: _____	ID. No. _____
	PIP Adjustor: _____		
	UM Adjustor: _____		

INCIDENT: Location: _____
Time: _____

Status: driver passenger pedestrian employee Weather: _____
 on the job at the time of the accident self-employed emp'r at time of MVA _____
 Police Report _____ Citations to: _____ for _____
 EMS/Ambulance _____ ER/Hosp. _____
 1st Tx _____ on ____ / ____ / ____
S/B worn not worn A/B deployed not deployed not avail. Windows ok cracked broken
Body Strike Interior @ X of Impact? no yes _____

Witness: (name, address, phone number) _____

VEH. DMG.: PTF amt: \$ pix: yes no interior Pd?: yes no tow: yes *to* no
VEH: brief description: current loc:

TF amt: \$ pix: yes no interior Pd?: yes no tow: yes *to* no
VEH: brief description: current loc:

Potential Defendant: driver owner emp'r

ADDRES:	PHN:	<input type="text"/>	SSN:	<input type="text"/>	D/B:	<input type="text"/>
	ST:	<input type="text"/>			Apt.	<input type="text"/>
	CITY:	<input type="text"/>			STATE/ ZIP:	<input type="text"/>
	emp'r	<input type="text"/>				
Brief Description:	<input type="text"/>					

INSURANCE: Type: BI WC Company: Pol. No.
 Ins'd: Coverage: Clm. No.

Adjustor: **Phone Number:**

Insurance Company Address:

Potential Defendant: driver owner emp'r

ADDRES:	PHN:	<input type="text"/>	SSN:	<input type="text"/>	D/B:	<input type="text"/>
	ST:	<input type="text"/>			Apt.	<input type="text"/>
	CITY:	<input type="text"/>			STATE/ ZIP:	<input type="text"/>
	emp'r	<input type="text"/>				
Brief Description:	<input type="text"/>					

INSURANCE: Type: BI WC Company: Pol. No.
 Ins'd: Coverage: Clm. No.

Adjustor: **Phone Number:**

Insurance Company Address:

INJURIES:	<input type="checkbox"/> H/A	<input type="checkbox"/> head injury	<input type="checkbox"/> TMJ/jaw pn	<input type="checkbox"/> LOC	<input type="checkbox"/> nightmares	<input type="checkbox"/> inability to sleep	<input type="checkbox"/> psch. Sx
	<input type="checkbox"/> nk pn	<input type="checkbox"/> shldr pn	<input type="checkbox"/> scap. pn	<input type="checkbox"/> hand pn	<input type="checkbox"/> arm pn	<input type="checkbox"/> wrist pn	<input type="checkbox"/> finger pn
	<input type="checkbox"/> UBP	<input type="checkbox"/> MBP	<input type="checkbox"/> LBP		<input type="checkbox"/> rib pn	<input type="checkbox"/> chest pn	
	<input type="checkbox"/> hip pn	<input type="checkbox"/> buttock pn	<input type="checkbox"/> leg pn	<input type="checkbox"/> knee pn	<input type="checkbox"/> ankle pn	<input type="checkbox"/> foot pn	<input type="checkbox"/> gait Sx
	<input type="checkbox"/> numb / ting. / para.			<input type="checkbox"/> radiating Sx			
	<input type="checkbox"/> Fx			<input type="checkbox"/> HNP			
	<input type="checkbox"/> Surgery						

PRIOR INJURIES:	
PRE-EXISTING MED'L CONDITIONS / SYMPTOMS:	

Ever charged with a criminal offense? Briefly Explain w/Details of Disposition and Location of Incarceration if applicable.	
Ever been involved in another law suit? Briefly explain, including giving info of County/Type/Your Status/Disposition.	
Marital Status	<input type="checkbox"/> single <input type="checkbox"/> last divorced from _____ on ____/____/_____ <input type="checkbox"/> widowed since ____/____/_____ <input type="checkbox"/> married to _____ on ____/____/_____ Children: _____; _____ d/o/b _____ ; _____ d/o/b _____ ; _____ d/o/b _____ ; _____ d/o/b

OTHER ACCIDENTS:	TYPE	APPROX. DATE	BRIEF DESCRIPTION
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	loc: _____
			descrip.: _____
			PR?(dept.) _____
			PD: _____
			Injuries: _____
			Tx With: _____
			Claim Filed?: _____ Disability?: _____
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	loc: _____
			descrip.: _____
			PR?(dept.) _____
			PD: _____
			Injuries: _____
			Tx With: _____
			Claim Filed?: _____ Disability?: _____
<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>	loc: _____
			descrip.: _____
			PR?(dept.) _____
			PD: _____
			Injuries: _____
			Tx With: _____
			Claim Filed?: _____ Disability?: _____

OTHER OWNED AUTOMOBILES

	Year	Make	Model	Insurance Co.	Policy #
1.					
2.					

OTHER RESIDENTS IN HOUSEHOLD

	Name	relation	Year	Make	Model	Insurance Co.	Policy #
1.							
2.							
3.							

ALL HCP'S

(including accident doctors, family doctors, dentists, prior doctors, specialists)

NAME/ FACILITY	LOCATION	TYPE	1 st Visit	Last Visit
		PCP now		
		PCP prior		
		orthodontist now		
		family dentist now		
		prior family dentist		
		chiropractor		
		prior chiropractor		
		accident m.d. or d.o.		

EMPLOYMENT

Employer _____

Address _____

Phone Number _____

Occupation _____

Date Started _____

Supervisor _____

Rate of Pay _____ **Hours per Day** _____

Hours per Week _____

EDUCATION

High School _____

City _____

Year _____

College _____

Degree _____

Year _____

Graduate _____

Degree _____

Year _____

DAILY DIARY INSTRUCTIONS

We would like you to start keeping a diary at once. This record will be very valuable throughout your case.

1. How these Injuries Have Affected Your Life.

We call it a "Daily Diary" because we want you to explain how, during a normal day, from the time you get up in the morning until you go to bed at night, how this occurrence has changed your life. For example, explain how it has affected the way you put on your clothes, the way you get in and out of bed, the way you take a bath, etc. Consider all aspects of your life, your work, your playtime, your hobbies, your life as a husband or wife, etc. Assess how it has affected your disposition, your personality, your nervousness, etc. We need to know how your injury has affected the marital relations between you and your spouse.

2. Your Pain and Suffering.

We want a description of your pain, both at the scene of the occurrence and at all times thereafter. We want to know whether or not it is a shooting pain, throbbing pain, etc. We want your words and not anyone else's.

3. Start at Your Head When Recording Your Complaints and Injuries.

A good rule to follow in order to remember all of your problems is to start at your head and go down through all parts of your body, moving from your head, neck, shoulders, etc. Explain in detail any problem that you have with each part of your body. Also, give details with regard to the medications you are taking and what they are for, if you know.

4. Don't Use the Words "I Can't."

Please do not use the words "I can't" because "can't" means physical impossibility. For example, you can't use your left hand, if you haven't got one. Don't say "I can't do it", "I never do it." We would prefer you would use such words as "I am not able to do it as well" or some other words meaning the same thing. You should always work towards the idea that "I am trying and I will continue to try to do more things." Everyone will admire you more if you try. In regard to your activities such as your housework, your yard work, your work at the office or factory, you should detail what things you are not able to do as well as before.

5. "My Diary" Witnesses.

We would like for you to contact your friends, neighbors, associates at work, etc., and on a separate sheet of paper for each witness give us his or her name, address and telephone number. Have each describe, or you describe in detail, what he or she knows about how this injury has changed your life. For example, your neighbor might tell about how you are not able to work as much around the house, or your friends could tell how you don't bowl now, or you don't engage in some other type of hobby. It is better if these witnesses are not your relatives. It is all right if they are your friends, because they would be more likely to have observed you. It is impossible to be too detailed.

6. Loss of Wages or Loss of Potential Income.

One of the major aspects of our case may be loss of income or potential income. We will need a copy of your union contract showing wage rates, copies of your W-2 forms and your income tax returns for at least the last five years. Please obtain from your employer the exact days you missed from work because of this accident and the amount of money you would have made if you would have been working these days. If this injury has prevented you from being advanced in your employment or has prevented you from obtaining employment, please give us the names, addresses and telephone numbers of witnesses who can prove this for you. We would also like to know in detail what services you have prevented from performing around the house, such as supervision of the children.

7. Questions or Help in Answering Your "Daily Diary."

If you need any help in keeping your records, please call this office for an appointment. Please do not come in without an appointment.

8. Use Your Imagination.

You know your own life better than we do. Use your imagination and go into all aspects of your life. Explain to us, in the greatest detail possible, how this occurrence has affected your life.

INSTRUCTIONS AND SUGGESTIONS FOR CLIENTS

Talk to No One.

Do not talk to anyone about your accident except one of our lawyers. You should always require identification to be sure to whom you are talking. Do not give statements without first notifying us so that we may be present if we desire. We will generally want these statements taken in our office or by conference call.

Your Doctor.

You should return to each of your doctors as often as necessary and should always tell them about all your complaints. If you see any additional doctors, be sure we are advised immediately of their names and addresses.

Record of Complaints.

Please keep a daily or weekly record of your complaints and progress. See "Daily Diary Instructions."

Wages and Earnings Lost.

Please keep an accurate record of all days lost from work because of your injuries and lost income.

Medical Bills.

Obtain and keep duplicate copies of all medical, hospital, and drug bills. You should periodically send these bills to us for our files. All your bills should be paid by check, or you should obtain and keep receipts. You should keep a list of all your medical bills and the costs incurred in going to your doctor.

Hospital and Doctor Bills.

Have your own auto insurance carrier pay hospital and doctor bills under the No Fault or Medical Payment provisions of your policy. You should also have your hospitalization insurance, such as Blue Cross and Blue Shield, pay on your bills.

Car Repair.

Do not have your automobile repaired until you have obtained pictures of it in its damaged condition. After pictures are taken, have your collision insurance carrier or the at-fault party's insurance carrier repair your car.

Traffic Offenses.

If you are arrested in connection with this accident, call one of the lawyers at the office immediately, and we will see that someone advises you. In the event of a coroner's inquest or other type of hearing, be sure to notify this office so that we will be able to represent you in connection with this inquest.

Witnesses.

Furnish to us immediately the correct names, addresses and telephone numbers of any and all witnesses.

Save your Cast, clothing or shoes.

If your injury requires a cast, brace, traction, or other appliance, save it. If you had a slip and fall save your clothing if damaged or stained and the shoes worn.

Photographs.

Send us the negatives and prints or any digital images of any photographs pertaining to your case. If you are required to be in the hospital and are receiving any type of treatment like traction or physical therapy try to get pictures.

Questions for us.

We will probably not contact you until we have something definite to report. We will be contacting you for depositions and answers to interrogatories and when your case goes to trial. If you have any specific questions in regard to these instructions or any other matters in regard to your case, please feel free to call or write us.

IMPORTANT – Change of Your Address.

Be sure to keep us advised of any change in your address or telephone number.