

GOLDSMITH & GOLDSMITH

Please complete this form as soon as possible and return it to our office. Do your best to be neat, and answer as many of the questions as you can. Be honest. This form will be kept confidential. If you need more space to answer a question, attach extra sheets. (Be sure to indicate which question you are answering.) If any of the questions or requests for information are not clear, please ask us about them.

Today's Date: _____

1. Who is filing out this form?

Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____

Work: _____

Cell: _____

Fax: _____

Date of Birth: _____

Social Security Number: _____

Your relationship to injured party: _____

2 Please answer these questions about the INJURED PARTY. Note: If you are the INJURED PARTY, every time you see "INJURED PARTY" in a question, this means you.

Name: _____

Maiden Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____

Work: _____

Cell: _____

Fax: _____

Date of Birth: _____

Place of Birth: _____

Date of Death: _____

Social Security Number: _____

Height: _____

Weight: _____

Smoker: Yes: _____ No: _____ If yes, how long? _____

Drink Alcohol: Yes: _____ No: _____ If yes, how much? _____

Parents:

Father: _____

Mother: _____

Spouse's Name: _____

Spouse's Date of Birth: _____

Spouse's Social Security Number: _____

Date of Marriage: _____

Place of Marriage: _____

3. Please list the name, address, telephone number and date of birth of ALL children, natural and/or adopted, of the INJURED PARTY.

(If the INJURED PARTY is a minor, please list the name, address, telephone number and date of birth of all brothers and sisters.)

(a) Name: _____

Date of Birth: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

(b) Name: _____

Date of Birth: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

(c) Name: _____

Date of Birth: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

(d) Name: _____

Date of Birth: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

4. Please list the names and ages of all grandchildren of the INJURED PARTY.

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

5. Please provide us with photographs of the INJURED PARTY and his/her family. Include photos of the INJURED PARTY alone, of the INJURED PARTY with spouse, with children, with grandchildren, etc. We will make copies of your photographs and return the originals to you. If you have negatives, send them instead of photographs.

6. Please list all marriages of the INJURED PARTY.

(a) Name of 1st spouse: _____

Date of Marriage: _____

Place of Marriage: _____

Date and Place of Divorce: _____

(b) Name of 2nd spouse: _____

Date of Marriage: _____

Place of Marriage: _____

Date and Place of Divorce: _____

(c) Name of 3rd spouse: _____

Date of Marriage: _____

Place of Marriage: _____

Date and Place of Divorce: _____

7. Has the INJURED PARTY ever been known by any name other than those names mentioned in question 3 above? If so, please list the name and briefly state why.

8. Please list all activities and memberships (church and civil) of the INJURED PARTY.

9. Please list all of the INJURED PARTY'S hobbies.

10. Please list the name, address, and phone number of all friend's, neighbors and/or co-workers who have knowledge of the INJURED PARTY before and after the incident.

(a) Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____

Work: _____

Cell: _____

Fax: _____

Relationship to INJURED PARTY: _____

(b) Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

Relationship to INJURED PARTY: _____

(c) Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

Relationship to INJURED PARTY: _____

(d) Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone Home: _____
Work: _____
Cell: _____
Fax: _____

Relationship to INJURED PARTY: _____

11. Please list all school and training courses attended by the INJURED PARTY (including those while in military service).

Elementary School: _____

City and State: _____

High School: _____

City and State: _____

Year of Graduation from High School: _____

If you did not graduate, date of GED or last grade attended: _____

College: _____

Degree: _____

Year of Graduation from College: _____

Any other school and/or training, dates attended, degree or certification received:

12. **PRIOR LAW SUITS OF CLAIMS.** Please list ALL lawsuits, including those for divorce, in which the INJURED PARTY has been involved as either a plaintiff (the one suing) or a defendant (the one being sued). In the case of a divorce, please list the date and place of the marriage.

(a) Name of Case: _____

Place & Court: _____

Year: _____ Type of Lawsuit: _____

Did you give a deposition? Yes _____ No _____

(b) Name of Case: _____

Place & Court: _____

Year: _____ Type of Lawsuit: _____

Did you give a deposition? Yes _____ No _____

13. **ARRESTS and/or PROSECUTIONS.** Please list ALL incidents (except minor traffic violations handled by mail). Include ALL situations in which the INJURED PARTY appeared before a Judge. List the dates or periods of time the INJURED PARTY was either on probation or in jail.

(a) Date: _____

Charge(s): _____

Place & Court: _____

Outcome: _____

(b) Date: _____

Charge(s): _____

Place & Court: _____

Outcome: _____

14. Who is the INJURED PARTY'S present employer?

Name: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Name of health/life insurance company: _____

Policy number: _____

15. Briefly describe INJURED PARTY'S job.

Rate of Pay: \$ _____

Date of Hire: _____

Date last worked: _____

16. Was the INJURED PARTY affiliated with any labor unions, professional associations, or other work-related organizations? If so, please list below, and indicate under "membership status" if position held was an officer.

(a) Organization: _____
Chapter, etc.: _____
Membership status: _____
Since when? _____

(b) Organization: _____
Chapter, etc.: _____
Membership status: _____
Since when? _____

17. Was the INJURED PARTY ever issued any Licenses or Certificates which related to profession or trade? If so, please list below.

(a) License or certificate: _____
Issued by whom? _____
Date issued: _____

(b) License or certificate: _____
Issued by whom? _____
Date issued: _____

18. Previous Employers. Please list all persons or businesses which employed the INJURED PARTY. This includes periods of self-employment.

(a) EMPLOYER: _____
Address: _____
Date or period: _____
Job description/title: _____
Rate of pay: \$ _____

(b) EMPLOYER: _____

Address: _____

Date or period: _____

Job description/title: _____

Rate of pay: \$ _____

(c) EMPLOYER: _____

Address: _____

Date or period: _____

Job description/title: _____

Rate of pay: \$ _____

(d) EMPLOYER: _____

Address: _____

Date or period: _____

Job description/title: _____

Rate of pay: \$ _____

MEDICAL HISTORY

Some of this information was covered by the interview, but please do not be concerned about that. Make every effort to be complete here, even though it means repeating some of your answers. THIS IS VERY IMPORTANT.

19. List **all doctors, dentists, or chiropractors** who have examined or treated the INJURED PARTY.

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

DOCTOR: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: _____

Date or Period: _____

Diagnosis: _____

Treatment: _____

20. Please list **all hospitals** where injured party has been a patient (including trips to the Emergency Room, Nursing Homes, Convalescent Centers, Sanitariums, Rehabilitations Institutions and other Institutions) during his or her entire lifetime.

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

HOSPITAL: _____

Street Address: _____

City, State and Zip Code: _____

Date or Period: _____

Attending doctor: _____

Diagnosis: _____

Treatment: _____

21. Please list all earnings lost due to accident or incident. You must be able to prove the lost earnings with appropriate evidence, such as, employment records, tax returns, etc. Please provide a copy of all paperwork proving such to our office.

(a) Time lost (by period): From: _____ to:

Rate of pay or earnings: _____

Amount of Loss: _____

(b) Time lost (by period): From: _____ to:

Rate of pay or earnings: _____

Amount of Loss: _____

(c) Time lost (by period): From: _____ to:

Rate of pay or earnings: _____

Amount of Loss: _____

22. Please list all medical expenses due to the accident, incident or injury. This includes all doctor, hospital, and medical bills (even if paid in whole or in part by insurance). List all other expenses you have had to pay, or still owe, due to your injury or illness that you think were caused by the defendant's negligence. Please provide a copy of all paperwork providing such to our office.

If INJURED PARTY is deceased, please list all funeral expenses and provide a copy of all paperwork providing such to our office.

23. Have you ever received compensation of any type during the time you have been recuperating from, or disabled by, the injury or illness in question? This compensation includes disability payments related to employment, private insurance benefits, state or federal disability payments, etc. Please list any such compensation and prove a copy of all paperwork proving such to our office.

(a) Source of Benefits: _____

Date Received: _____

Amount Received: \$ _____

(b) Source of Benefits: _____

Date Received: _____

Amount Received: \$ _____

(c) Source of Benefits: _____

Date Received: _____

Amount Received: \$ _____

(d) Source of Benefits: _____

Date Received: _____

Amount Received: \$ _____

24. Has any action been filed against the INJURED PARTY (or his or her family) for outstanding bills arising from the injury that led to this lawsuit? If so, please state when and where the action was filed.

If yes, please provide our office with a copy of any such release and a detailed description of the agreement:

STOP!

28. Please complete the following ONLY if your matter concerns a birth injury incident.

PRENATAL GENETIC SCREEN

(a) Will you be 35 years or older when the baby is due Yes ___ No ___

(b) Have you, the baby's father, or anyone in either of your families had any of the following disorders:

- Down's Syndrome (mongolism) Yes ___ No ___
- Other chromosomal abnormality Yes ___ No ___
- Neural tube defect, i.e., spina bifida, (meningomyelocele or open spine), anencephaly Yes ___ No ___
- Hemophilia Yes ___ No ___
- Muscular dystrophy Yes ___ No ___
- Cystic fibrosis Yes ___ No ___

If yes, indicated the relationship of the affected person to you or to the baby's father.

(c) Do you or the baby's father have a birth defect? Yes ___ No ___

If yes, who has the defect and what is it?

(d) In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in questions (b) above? Yes ___ No ___

If yes, what was the defect and who had it?

(e) Do you or the baby's father have any close relatives with mental retardation?

Yes ___ No ___

If yes, indicate the relationship of the affected person to you or the baby's father

Indicate the cause, if known.

(f) Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or chromosomal abnormality not listed above?

Yes ___ No ___

If yes, indicate the condition and the relationship of the affected person to you or to the baby's father.

(g) In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous pregnancy losses? Yes ___ No ___

Have with of you had a chromosomal study? Yes ___ No ___

If yes, indicate who and the results.

(h) If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes ___ No ___

If yes, indicate who and the results

(i) If you or the baby's father are African-American, have either of you been screened for the sickle cell trait? Yes ___ No ___

If yes, indicate who and the results.

(j) If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for B-thalassemia? Yes ___ No ___

If yes, indicate who and the results.

(k) If you or the baby's father are of Philippine or Southeast Asia ancestry, have either of you been tested for A-Thalassemia? Yes ___ No ___

If yes, indicate who and the results.

(l) Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (Including non-prescription drugs) Yes ___ No ___

If yes, give the name of the medication and time taken during pregnancy.
