Hunking Law, LLC

GENERAL INFORMATION

Date of Accident: _____ Today's Date: _____

Drivers License Number: _____ Office Location: _____

☐ Male ☐ Female

Full Legal Name: _____ _____

First Middle Last Maiden name or Other names used

Street Address: _____ Home #: _____

City, State, Zip: _____ Work # _____

Date of Birth: _____ Age: _____ Cell #: _____

SSN#: _____ E-mail: _____

Referred by: _____ Spouse's Name: _____

If Minor child, Mother's and Father's names: _____

DRIVER OF YOUR VEHICLE:	**OTHER DRIVER**
Name:	
Street Address:	
City, State, Zip:	
Phone #:	
Drivers' License No.:	
Descr. of Vehicle:	
Plate #:	
Insurance Carrier:	
Address:	
Claim Number.:	
Adjuster's Name :	
Adjuster's Phone #:	
IF DIFFERENT Owner's Name:	
Owner's Address:	

ACCIDENT INFORMATION

City and County Where Accident Occurred: _____

Location of Accident: _____

Time of Accident: _____

Describe how the accident happened: _____

_____

_____

_____

_____

Describe conversations at the scene: _____

_____

Describe damage to your vehicle: _____

Describe damage to other vehicle: _____

Your estimate of repair cost:_____Estimate of other vehicle's repair cost: _____

Please provide photographs of your damaged vehicle, the scene of the accident, and any visible injuries. In addition, please provide a copy of any repair estimates to your vehicle.

Has your property damage been resolved with the insurance carrier? ____ YES / ____ NO

Weather conditions: _____

Road Conditions:_____ Posted speed limit: _____

Were you working at the time?:_____Were you wearing seat belt? Lap and shoulder? _____

Were you aware of the pending crash: _____

Were you stopped, speeding up or slowing down at the time if impact? _____

If your vehicle was towed who towed it?: _____

Name any police agencies that reported to the scene: _____

Was anyone cited?:_____ If so, for what?: _____

Were you taken from the scene by ambulance? _____

If so which one?: _____

List the witnesses, their addresses, and phone numbers:

1. _____
2. _____
3. _____

Passengers in your vehicle, their addresses and phone numbers:

1. _____
2. _____

EDUCATION

Highest Grade completed:_____ Special Training: _____

WAGE LOSS

Employer's Name: _____

Address:_____

Description of Job Duties: _____

Days of work missed:_____ Wages:_____

Keep track of all days you miss from work as a result of your injury.

Has PIP paid any of your wage loss benefits? YES / NO ____

Have you received Unemployment benefits from the State of Oregon related to this accident? ____ YES / ____ NO

Have you been receiving Disability benefits from your Employer related to this accident? ____ YES / ____ NO

INJURIES

Headaches?	Yes: _____	No: _____
Dizziness?	Yes: _____	No: _____
Nausea?	Yes: _____	No: _____
Loss of Balance?	Yes: _____	No: _____
Ringing in ears?	Yes: _____	No: _____
Blurred Vision?	Yes: _____	No: _____
Loss of memory?	Yes: _____	No: _____
Fluid in Ears?	Yes: _____	No: _____
Jaw pain?	Yes: _____	No: _____
Clicking in jaw?	Yes: _____	No: _____
Eating/chewing difficulty?	Yes: _____	No: _____
Numbness/tingling in arms/hands/fingers (R/L)?	Yes: _____	No: _____
Numbness/tingling in legs and/or feet (R/L)?	Yes: _____	No: _____
Neck pain?	Yes: _____	No: _____
Shoulder pain?	Yes: _____	No: _____
Mid-back?	Yes: _____	No: _____
Low back?	Yes: _____	No: _____
Hip pain?	Yes: _____	No: _____

IMPAIRED ACTIVITIES (circle those that apply)

badminton	soccer	walking	ice skating	photography	rowing/boating
boxing	baseball	jogging/running	gymnastics	basketry	fishing
handball	hockey	aerobic exercises	yoga	gardening	backpacking
judo	karate	health clubs	snow skiing	card playing	camping
volleyball	football	weight lifting	swimming	painting	hunting
archery	racquetball	bicycling	dancing	horseback riding	rafting
basketball	tennis	fencing	flying	water skiing	
softball	bowling	golf	sailing		

DAY-TO-DAY ACTIVITIES

housecleaning	dining out	bathing/showering	playing w. children
laundry	vacation	shampooing hair	watching TV
cooking	traveling	brush teeth	movie going
eating	holidays	shaving	car washing
yard work	church events	dressing	sleeping
shopping	social events	sexual relations	

WORK-RELATED ACTIVITIES

sitting	telephoning
standing	computer work
bending	typing
lifting	writing
moving	reading

OTHER INJURIES/SYMPTOMS/COMMENTS: _____

_____

_____

Did you strike anything within your vehicle?_____If so, what? _____

Initial complaints (when) and first treatment: _____

_____

_____

List names, addresses (including zip codes) of all physicians and medical facilities you have seen for this accident:
Keep and send copies of all medical billings you receive.

1. _____

2. _____

3. _____

4. _____

5._____

Name of Primary Care Physician: _____

PREVIOUS INJURIES List all previous injuries (including any on the job injuries) :

	Date	Injury	Physician
1.			
2.			
3.			
4.			
5.			

Other prior medical history: _____

_____

_____

BANKRUPTCIES

Have you filed for bankruptcy ? ____ YES / ____ NO

Are you planning on filing for bankruptcy? ____ YES / ____ NO

Name and address of bankruptcy attorney: _____

_____

_____

PRIOR LITIGATION

Have you ever filed a lawsuit for personal injuries (other than this claim)? ____ YES / ____ NO

Please provide details: _____

_____

_____

HEALTH INSURANCE

Do you have private health insurance? ____ YES / ____ NO

Has your health insurance carrier paid any accident related medical expenses? ____ YES / ____ NO

Please provide a copy of the health insurance card.

Member Name: _____

Group Name/Number: _____

Identification Number: _____

Has your health insurance paid or been billed for any of your accident related medical expenses?

____ YES / ____ NO

Are you a Medicare beneficiary? ____ YES / ____ NO

Please provide a copy of the health insurance card.

Medicare Claim Number: _____

Has Medicare paid or been billed for any of your accident related medical expenses? ____ YES / ____ NO

Are you a Medicaid/OHP beneficiary? ____ YES / ____ NO

Please provide a copy of the health insurance card.

Medicaid Claim Number: _____

Has Medicaid paid or been billed for any of your accident related medical expenses? ____ YES / ____ NO

Do you receive benefits from the State of Oregon through the Adult & Family Services Division / Department of Human Services? ____ YES / ____ NO

In what form? _____

Are you eligible for SSD (Social Security Disability) or SSI (Supplemental Security Income) ____ YES / ____ NO