

File No.: \_\_\_\_\_ Date File Opened \_\_\_\_\_ S/L \_\_\_\_\_

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**MEDICAL MALPRACTICE CLIENT QUESTIONNAIRE**

Note: If extra room is needed for answering any of the questions below, please attach a sheet of paper to questionnaire with number of section you are answering.

Date form Completed: \_\_\_\_\_

**SECTION NO. 1**

Victim's full Name \_\_\_\_\_

Address \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date/place of birth \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Position Held \_\_\_\_\_

Name, address and telephone number of person to contact in case of emergency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Victim's Spouse \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ Date married \_\_\_\_\_

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Spouse's telephone Number (home)\_\_\_\_\_ (work)\_\_\_\_\_

Spouse's employer & position held\_\_\_\_\_

**CHILDREN**

Name	Address	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

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**Section No. 2**

(A) If the victim is deceased, has an estate been opened? If so, please attach a copy of the Certificate of Appointment showing who is responsible for the estate. Date of death\_\_\_\_\_

(B) If the victim was under 18 years of age, please complete the questions below:

Father's name:\_\_\_\_\_

Mother's name:\_\_\_\_\_

If parents of minor are divorced or separated, list the custodial parent's name, address and phone number:

\_\_\_\_\_

(C) If victim is incompetent to handle his/her own affairs, has someone been appointed guardian or conservator for the victim? If so, give name, address and phone number of person appointed and send copies of documents showing the appointment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you conferred with any other attorney regarding your complaint of medical malpractice?

Yes\_\_\_\_\_ No\_\_\_\_\_. If answer is yes, please state with whom you conferred and whether you have signed a fee contract with that attorney.\_\_\_\_\_

\_\_\_\_\_

Where did you hear about this firm:\_\_\_\_\_

Attorney \_\_\_\_\_ Friend \_\_\_\_\_

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Yellow pages Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, which telephone book? \_\_\_\_\_

Other \_\_\_\_\_

Have you been involved in any previous lawsuits? Yes \_\_\_\_\_ No \_\_\_\_\_

If answer is yes, please state details: \_\_\_\_\_

Have you ever been charged with a crime: Yes \_\_\_\_\_ No \_\_\_\_\_

If answer is yes, please state details: \_\_\_\_\_

\_\_\_\_\_

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**SECTION NO. 4**

Date of incident which led you to believe medical malpractice was committed: \_\_\_\_\_

What made you think the doctor, hospital employees or other healthcare providers may have been guilty of medical malpractice? \_\_\_\_\_

\_\_\_\_\_

List all doctors and/or hospitals whom you feel committed medical malpractice.

Name of hospital or Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Complications: \_\_\_\_\_

Name Treated Under: \_\_\_\_\_

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Date of Last Treatment: \_\_\_\_\_

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Name of Hospital or Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Treatment: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Complications: \_\_\_\_\_

Name Treated Under: \_\_\_\_\_

Date of Last Treatment: \_\_\_\_\_

Has any doctor, hospital employee or other healthcare provider told you there was negligence involved in the treatment Yes \_\_\_\_\_ No \_\_\_\_\_

If answer is yes, please state name, address and telephone number of person and the details of your conversation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**SECTION NO.:5**

List family members or friends who can furnish us information which may be helpful in evaluating the case:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Relationship to victim: \_\_\_\_\_

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**SECTION NO.: 6**

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List all hospitals and doctors who treated the victim as a result of the malpractice including the ones who may have committed malpractice:

Name of Doctor and Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Complications: \_\_\_\_\_

Name Treated Under: \_\_\_\_\_

Date of Last Treatment: \_\_\_\_\_

\*\*\*\*\*

Name of Doctor or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

Complications: \_\_\_\_\_

Name Treated Under: \_\_\_\_\_

Date of Last Treatment: \_\_\_\_\_

\*\*\*\*\*

Name of Doctor or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_

Reason for Treatment: \_\_\_\_\_

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Complications: \_\_\_\_\_

Name Treated Under: \_\_\_\_\_

Date of Last Treatment: \_\_\_\_\_

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**SECTION No.: 7**

Did medical insurance pay any of the medical bills?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please state name and address of company:

\_\_\_\_\_  
\_\_\_\_\_

What are the approximate total medical bills as a result of the malpractice?

\_\_\_\_\_

Did the victim miss any work as a result of the medical malpractice? If answer is yes, total amount of lost wages:

\_\_\_\_\_

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**SECTION No.:8**

Is there any other information you feel we need to know to assist us in evaluating the medical malpractice case? If answer is yes, please state details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SECTION No.:9**

WRITE A COMPLETE STATEMENT OF ALL THAT HAPPENED WHICH MAKES YOU FEEL THERE MAY HAVE BEEN MALPRACTICE. PLEASE INCLUDE A STATEMENT OF HOW THE INJURY HAS AFFECTED THE VICTIM AND HIS/HER FAMILY. BE AS COMPLETE AS POSSIBLE.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

