Johnson, Chiligiris & Weatherford
Lawyers

412 South Franklin Street • Decatur, Illinois 62523-1388
217.422.2280 • 217.422.0622 fax • www.decaturlawoffice.com

PERSONAL INJURY FACT SHEET

Clients frequently have a great deal of valuable information concerning how and why their accident occurred and who was at fault. Good lawyers should be aware of this and listen to their clients. Please help me help you by answering the following questions in as much detail as you can. Any problem important enough to see a lawyer is important enough to complete this form.

Injured Party's Full Name_____ Today's Date _____

(If a minor, name of parent) _____ Minor's D.O.B. _____

Employer's Name & Address _____

Employer's Telephone_____ Job Title_____

Weekly Income _____ Length of employment through said employer _____

1. Dates lost from work _____ Date of Injury Time of Day _____

   Day of the Week _____ Location _____

   Weather Conditions _____

2. Name, Address, and Phone Number of the Person(s) who caused your injury_____

   _____

3. Names and Addresses of any witnesses to the accident _____

   _____

   _____

   _____

4. Names and Addresses of person(s) who knew you prior to the accident (family, friends, etc.) _____

   _____

   _____

   _____

5. Was the accident reported?_____ If so, to whom? _____

   When? _____

Describe in detail what happened. _____

_____

_____

_____

_____

_____

_____

If this was a car accident, draw the scene of the collision in the space below. Identify streets and highways by name or number. Number each vehicle. Use arrows to show the direction you were headed.

Describe your bodily injury. _____

_____

_____

_____

_____

_____

Check any areas of bodily injury:

☐ A - Abrasion ☐ AM - Amputation ☐ B - Burn

☐ BL - Blister ☐ D - Decubitus ☐ E - Erythema

☐ H - Hematoma ☐ L - Laceration ☐ R - Rash

☐ S - Scar ☐ O - Other ☐ T - Tattoo

Please ✓ and describe the permanent effects of your injury, including fractures, deformities, stiffness, scarring, swelling, or pain.

☐ Atrophy ☐ Swelling ☐ Stiffness

☐ Deformity ☐ Limitation of Motion

Comment about the permanent effects of your injury:

_____

_____

_____

INSURANCE INFORMATION

Your Auto Insurance Company Name _____

Company Address _____

Agent Name _____ Date of Report _____

Telephone Number _____

Other Person's Auto Insurance Company Name _____

Company Address _____

Agent Name _____ Date of Report _____

Telephone Number _____

Your Medical Insurance Company Name _____

Company Address _____

Agent Name _____ Date of Report _____

Telephone Number _____

MEDICAL INFORMATION

Who treated you for your injury?

Name of Doctor or Hospital _____ Amount Billed _____

Address _____ Telephone Number _____

Name of Ambulance Service _____ Amount Billed _____

Address _____ Telephone Number _____

Name of Chiropractor or Physical Therapist _____ Amount Billed _____

Address _____ Telephone Number _____

List all accidents wherein you have suffered injury in the last ten years.

Place _____ Date _____

Type of injury _____

Place _____ Date _____

Type of injury _____

Place _____ Date _____

Type of injury _____

Place _____ Date _____

Type of injury _____