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CONFIDENTIAL CLIENT QUESTIONNAIRE

Instructions to Client: This form is for our file, and for our reference only. No one else will see this form so you do not need to worry about how you word or spell your answers. We will rely upon your answers, so please be candid, complete and truthful. You may write/type on the front/back of these pages and/or attach additional pages, if necessary. You may also type your answers on separate paper (if you do this, please number your answers to correspond to the questionnaire's questions). Please complete all questions with as much detail and accuracy as possible, even if you have already provided us with some/all of this information.

1. Name:

   Former Names (maiden, divorced, name change, etc.):

2. Address:

   Phone (home):
   Phone (cellular):
   Phone (work):
   Home email address:
   Work email address:

   Preferred method of communication (check one):

   _____ Home phone
   _____ Cellular phone
   _____ Work phone
   _____ Home email
   _____ Work email

3. Date of Birth:

4. Place of Birth:

5. Social Security Number:

6. Marital Status (circle one):

   Single Married Divorced Separated Widow[er] Common Law

7. If married:

    a. Date of marriage:

    b. City and State of marriage:

    c. Spouse's:

        i. Name:

        ii. Former name[s]:

        iii. Address:

        iv. Phone (home):
        Phone (cellular):
        Phone (work):
        Home email address:
        Work email address:

        v. Date of birth:

        vi. Place of birth:

        vii. Social Security number:

    d. If divorced:

        i. Name of former spouse:
        ii. Date of divorce:

    e. If widowed:

        i. Date of spouse's death:

    f. If common law:

        i. How long have you been living together:

8. Children (including adult children):

    a. Full name(s) and dates of birth:

    Name DOB

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

9. Health Insurance

    a. Who is your health insurance provider?

    ☑ **Please provide us with a copy of your insurance card.**

        i. Name:

        ii. Address:

        iii. Policy number:

        iv. Group number:

        v. Plan identification number:

b. Are you (or have you ever been) a MEDICARE recipient?

☑ **Please provide us with a copy of your Medicare card.**

i. If yes:

1. When did you start receiving Medicare benefits?

2. What is your Health Insurance Claim Number (HICN)?

c. Are you (or have you ever been) a MEDICAID recipient?)?

☑ **Please provide us with a copy of your Medicaid card.**

i. If yes:

1. Which county provides your benefits?

2. When did you start receiving Medicaid benefits?

3. What is your Medicaid number?

10. For MEDICAL MALPRACTICE lawsuits only:

    a. Date(s) of possible malpractice:

    b. Which physician(s), hospital(s) and/or other health care provider(s) do you believe were negligent?

Provider Name	Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

    c. Briefly, why do you believe that the provider(s) listed in response to question 10(b) were negligent?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

d. What is the first date of treatment with the provider(s) listed in response to question 10(b)?

Provider Name	Date of FIRST treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

e. What is the last date of treatment with the provider(s) listed in response to question 10(b)?

Provider Name	Date of LAST treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

f. Are you treating with any other medical providers for anything? If so, please provide:

Provider Name	Reason for treatment
_____	_____
_____	_____
_____	_____

11. For NON-MEDICAL MALPRACTICE lawsuits only:

    a. Day, time and place of accident/injury:

    b. Brief description of accident/incident:

12. Description of Injury:

    a. Describe all injuries and/or diagnoses:

    b. Which still bother you? In what way?

    c. Has your doctor indicated that there will be any permanent or long-lasting effects? If so, what?

    d. Describe any scars by size and location.

e. Do you have photographs of your injuries?

_____ Yes

_____ No

☑ **Please preserve and provide us with copies of any photographs.**

f. Has a doctor told you that further treatment be needed? If so, which doctor, what treatment, and when?

g. Prior to this injury/incident/accident, did you have any injuries to, disease(s) of, condition(s) affecting and/or problem(s) with the same body part, system or area?

_____ Yes (if yes, please explain below)

_____ No

Note: Describe your prior injury, disease, condition, or problem and, provide the name(s) and address(es) of all health care providers who treated you for this injury, disease, or problem (if you did not treat with anyone, please provide a description followed by "no treatment") below:

Medical Providers For This Injury/Disease/Condition/Problem:

Provider Name:	Address:
_____	_____
_____	_____
_____	_____

h. Prior to this incident/accident, did you have any other medical conditions, diseases, or injuries to any other area of your body?

_____ Yes (if yes, please explain below)

_____ No

Note: Describe the condition/injury, date of injury (if applicable) and also provide a list of the names and addresses of all health care providers who you treated with or continue to treat with for this condition, disease or injury (if you did not treat with anyone, please provide a description followed by "no treatment") below:

Medical Providers For This Injury/Disease/Condition/Problem:

Provider Name:	Address:
_____	_____
_____	_____
_____	_____

13. Medical treatment following the accident/incident:

a. Hospitals – please provide us with full names, addresses, dates admitted and dates of discharge:

b. Physicians – please provide us with full names and addresses (include physician's group name):

c. Other treatment (ambulance, pharmacy, physical therapy, chiropractor, dentist, x-rays, laboratory, medical supply companies, etc.) - please provide us with full names and addresses:

14. How long were you confined to bed at home by doctor's orders, because of your injuries? Please explain confinement. Provide dates. If not confined, write "none."

15. How long were you confined to home, but not to bed, because of your injuries? Please explain confinement. Provide dates. If not confined, write "none."

16. Give names and addresses of all witnesses to the accident/incident.

17. Lost wages.

☑ **If you believe you have lost wages, vacation time, sick time, health insurance, etc., due to your injury, we will need information about your income sources and benefits in order to present proof of damage.**

☑ **Please provide us with copies of:**

- **Your state and federal income tax returns, including W-2s, for 5 years before the injury date through the most recent filing year;**
- **An employer benefit summary, if any; and**
- **Pay stubs that show use of vacation/sick/personal time.**

a. Where were you employed when you were injured?

i. Name of employer:

ii. Address:

iii. When (month/year) did you start working for this employer?

iv. What was your title/position when you were injured?

v. Number of hours worked per week?

vi. What were your job responsibilities?

vii. What was your hourly wage and/or salary when you were injured (please provide gross income, not take-home pay)?

viii. What dates were you unable to work (on doctor's orders)?

ix. Did you lose wages, income, benefits, etc., and, if so, please provide an approximate total and explain how you arrived at that figure?

b. Where are you currently employed (if you are still employed by the same employer, write "SAME").

i. Name of employer:

ii. Address:

iii. When (month/year) did you start working for this employer?

iv. What was your title/position when you were injured?

v. What were your job responsibilities?

v. What was your hourly wage and/or salary when you were injured (please provide gross income, not take-home pay)?

vi. What dates were you unable to work (on doctor's orders)?

vii. Did you lose wages, income, benefits, etc., and, if so, please provide an approximate total and explain how you arrived at that figure?

18. Were you attending school at the time of the accident/incident? If so:

a. What was/is the name and address of the school?

b. What grade or program were you in?

c. Did you miss time from school? If so, provide dates.

d. Did you graduate?

e. If you did not graduate because of your injury, when did you plan to graduate?

f. Do you have plans to return?

g. Effect on you of losing that time from school (e.g., job prospects, college prospects, military enrollment, promotions, etc.).

19. Who has been paying your medical bills and lost wages, if any? (For example: Blue Cross Blue Shield, Aetna, Medicare, Medicaid, Social Security, Workers' Compensation, No-Fault, self-pay, etc.)?

    a. Name of company/entity:

    b. Address:

    c. Policy number:

    d. Group number:

    e. Other identification number(s):

20. Has anyone else made any payments for anything on your behalf (mortgage or loan disability insurance, etc.)? If so, please explain and provide name, address and identification number of person/entity who made payments.

21. If you have applied for, or are receiving, Social Security Disability income benefits as a result of this injury, please provide the following information:

    a. Date of award or date of hearing:

    b. Schedule of payments received (dates, weekly amounts, etc.):

    c. Name, address and phone of your local Social Security office and contact person:

    c. Name of attorney, if any, who handled your application:

22. Do you have any out-of-pocket medical expenses? For example, doctor visit co-pays, prescription co-pays, hotel stays for medical care, etc. If so, please provide us with an estimate of your out-of-pocket expenses, below, and forward any information in this regard with receipts, if any, for who was paid, when, and the amount(s) paid.

23. Do you have any activity restrictions (include work, school, jobs around house, recreation, social activities, etc.)?

_____ Yes

_____ No

a. By way example, as this is not an exhaustive list, what HOUSEHOLD ACTIVITIES did you participate in before the accident/incident that you could not do after you were injured (check all that apply):

Before accident/incident:	After accident/incident:
_____ Plan/Prepare meals	Yes ___ No ___ Limited ___
_____ Set/Clear table	Yes ___ No ___ Limited ___
_____ Hand wash dishes	Yes ___ No ___ Limited ___
_____ Load dishwasher	Yes ___ No ___ Limited ___
_____ Sort laundry into loads	Yes ___ No ___ Limited ___
_____ Load washer/dryer	Yes ___ No ___ Limited ___
_____ Wash clothes	Yes ___ No ___ Limited ___
_____ Hang laundry to dry	Yes ___ No ___ Limited ___
_____ Iron	Yes ___ No ___ Limited ___
_____ Fold/put away clothes	Yes ___ No ___ Limited ___
_____ Clean counter/stove top	Yes ___ No ___ Limited ___
_____ Clean drawers	Yes ___ No ___ Limited ___
_____ Clean cabinets/cupboards	Yes ___ No ___ Limited ___
_____ Clear fridge/freezer	Yes ___ No ___ Limited ___
_____ Clean sink	Yes ___ No ___ Limited ___
_____ Clean microwave	Yes ___ No ___ Limited ___
_____ Make bed	Yes ___ No ___ Limited ___
_____ Put away clothes	Yes ___ No ___ Limited ___
_____ Tidy closet	Yes ___ No ___ Limited ___
_____ Pickup toys	Yes ___ No ___ Limited ___
_____ Dry mop	Yes ___ No ___ Limited ___
_____ Wet mop	Yes ___ No ___ Limited ___
_____ Sweep (indoor)	Yes ___ No ___ Limited ___
_____ Vacuum	Yes ___ No ___ Limited ___
_____ Shampoo carpets	Yes ___ No ___ Limited ___
_____ Wax floors	Yes ___ No ___ Limited ___
_____ Clean bathrooms	Yes ___ No ___ Limited ___
_____ Clean shower and tub	Yes ___ No ___ Limited ___
_____ Clean toilets	Yes ___ No ___ Limited ___
_____ Clean mirrors	Yes ___ No ___ Limited ___

_____ Dust	Yes ___	No ___	Limited ___
_____ Wash windows	Yes ___	No ___	Limited ___
_____ Take out trash	Yes ___	No ___	Limited ___
_____ Paint (indoor)	Yes ___	No ___	Limited ___
_____ Feed pets	Yes ___	No ___	Limited ___
_____ Groom pets	Yes ___	No ___	Limited ___
_____ Walk pets	Yes ___	No ___	Limited ___
_____ Grocery shop	Yes ___	No ___	Limited ___
_____ Mow lawn	Yes ___	No ___	Limited ___
_____ Clean pool	Yes ___	No ___	Limited ___
_____ Rake leaves/grass	Yes ___	No ___	Limited ___
_____ Wash cars	Yes ___	No ___	Limited ___
_____ Paint (outdoor)	Yes ___	No ___	Limited ___
_____ Roofing repair	Yes ___	No ___	Limited ___
_____ Siding repair	Yes ___	No ___	Limited ___
_____ Plant shrubs, etc.	Yes ___	No ___	Limited ___
_____ Weeding	Yes ___	No ___	Limited ___
_____ Weed-wack	Yes ___	No ___	Limited ___
_____ Shovel snow	Yes ___	No ___	Limited ___
_____ Spread ice melt	Yes ___	No ___	Limited ___
_____ Fill birdfeeders	Yes ___	No ___	Limited ___

Other(s):

For how long were those activities restricted?

b. By way of example, as this is not an exhaustive list, what RECREATIONAL ACTIVITIES and/or HOBBIES did you participate in before the accident/incident that you could not do after you were injured (check all that apply):

Before accident/incident:	After accident/incident:
_____ Sports (which?)	Yes ___ No ___ Limited ___
_____ Exercise	Yes ___ No ___ Limited ___
_____ Dancing	Yes ___ No ___ Limited ___
_____ Music	Yes ___ No ___ Limited ___
_____ Fishing	Yes ___ No ___ Limited ___
_____ Camping	Yes ___ No ___ Limited ___
_____ Hiking	Yes ___ No ___ Limited ___
_____ Reading	Yes ___ No ___ Limited ___
_____ Writing	Yes ___ No ___ Limited ___
_____ Hunting	Yes ___ No ___ Limited ___
_____ Knitting	Yes ___ No ___ Limited ___
_____ Pottery	Yes ___ No ___ Limited ___
_____ Four-wheeling	Yes ___ No ___ Limited ___
_____ Travel	Yes ___ No ___ Limited ___
_____ Fine arts	Yes ___ No ___ Limited ___
_____ Wood-working	Yes ___ No ___ Limited ___
_____ Animals	Yes ___ No ___ Limited ___
_____ Scrap-booking	Yes ___ No ___ Limited ___
_____ Board games	Yes ___ No ___ Limited ___
_____ Collecting (what?)	Yes ___ No ___ Limited ___
_____ Gardening	Yes ___ No ___ Limited ___

Other(s):

For how long were those activities restricted?

c. By way of example, as this is not an exhaustive list, what SOCIAL ACTIVITIES (including league and organizational activities) did you participate in before the accident/incident that you could not do after you were injured (check all that apply):

Before accident/incident:	After accident/incident:
_____ Leagues	Yes ___ No ___ Limited ___
_____ Religious services/groups	Yes ___ No ___ Limited ___
_____ Dining out	Yes ___ No ___ Limited ___
_____ Movies	Yes ___ No ___ Limited ___
_____ Rotary club	Yes ___ No ___ Limited ___
_____ PTO/PTA	Yes ___ No ___ Limited ___
_____ Athletic boosters	Yes ___ No ___ Limited ___
_____ Volunteering	Yes ___ No ___ Limited ___

Other(s):

For how long were those activities restricted?

24. For how long was your spouse deprived of your services because of your injuries? Describe the services lost.

25. Did you have to pay anyone to do the things you could no longer do because of your injury? (Examples: housework, mowing the lawn, snow shoveling, painting, child care, etc.) If so, give name and address of person(s) hired, dates, and amount(s) paid. If not, write "NONE."

26. Criminal Record.

a. Have you ever been convicted of a crime? If so, when and for what? If not, write "NONE."

27. Bankruptcy

☑ **Please notify us before you file for bankruptcy. If you file without telling us, it can have a negative impact upon your case.**

a. Have you ever filed for bankruptcy?

_____ Yes

_____ No

i. If yes, when and what is the status of the proceeding?

ii. Who was/is your bankruptcy attorney?

28. Social Networking/Media.

☑ **The defendant(s) <u>will</u> investigate you online to see if you have a social networking presence, to see what you are writing and posting, to see what others are writing and posting about you, and to secure pictures of you.**

☑ **You <u>must</u> assume that the defendant(s) will find anything you post, as well as anything posted about you, and will attempt to use it against you.**

☑ **We recommend that you do <u>not</u> post pictures of yourself, create text about yourself, or otherwise post any information about yourself to social media sites (including, e.g., pictures, wall posts, status updates, foursquare invites, tweets, etc.).**

a. Do you have an account with (check all that apply):

_____ Facebook
_____ MySpace
_____ Twitter
_____ Classmates
_____ Flickr
_____ Foursquare
_____ Friendster
_____ LinkedIn
_____ MyLife
_____ Dating Websites (e.g., Cupid, Match.com)
_____ Employment Websites (e.g., Resume.com)
_____ Other: _____

b. Have you posted text and/or pictures about/of yourself to your account(s) since your injury?

_____ Yes

_____ No

If yes, please describe/explain:

c. Are your account settings “private?”

_____ Yes

_____ No

☑ **Consider making all account settings <u>private</u> to protect your personal information.**

d. Do you blog? If so, provide address(es) of blogs. If not, write “NONE.”

e. Do you run a personal website? If so, provide website address. If not, write “NONE.”

f. Do you post videos of yourself to YouTube? If so, provide title and date of last video posted. If not, write “NONE.”

29. For MOTOR VEHICLE ACCIDENTS only:

a. Who is your automobile insurer?

i. Name:

ii. Address:

iii. Policy number:

iv. Name and address of agent/broker:

b. Do you have homeowner's insurance and, if so, what is the provider's name and address, and what is the policy number?

c. Do you have renter's insurance and, if so, what is the insurer's name and address, and what is the policy number?

d. Do you have an umbrella and/or excess insurance and, if so, what is the insurer's name and address, and what is the policy number?

e. List the names of all people living in your household who owned a vehicle at the time of the accident and list the name, address and policy number of their auto insurance carrier at that time.

f. Who paid for damage to your automobile, towing, rental, or any other expense involved with the damage to your vehicle? Please list their company name, address, claim number, etc., as well as all detailed financial information including the amount they paid you, deductibles you had to pay, etc.

f. Do you have pictures of damage to the vehicle?

_____ Yes

_____ No

☑ **Please preserve the pictures and provide us with copies.**

g. Do you have a copy of the police accident report?

_____ Yes

_____ No

☑ **Please provide us with a copy.**

30. Do you keep a journal and/or log in which you have record any details relating to your claim for medical malpractice and/or personal injury?

_____ Yes

_____ No

☑ **Please preserve the journal. We may need to review it and may need to produce some or all of the contents to the defendants.**

31. For cases involving a WRONGFUL DEATH:

a. Name and address of decedent (i.e., the deceased person):

b. Citizenship of the decedent:

c. Name and address of surviving spouse if any:

d. Name and address of the decedent's surviving parent(s), if any:

e. Name and address of the decedent's surviving siblings:

f. List the names of all of the decedent's children (natural and adopted):

g. List the names of everyone who was "dependent" upon the decedent for financial support and the amount of support. For example, husband makes $30,000 per year and wife makes $15,000 per year. They have 4 children between the ages of 3 and 12. Husband and wife pool their income. Husband dies. Of the $45,000 they made per year, 2/3 came from the husband, so he provided 2/3 of his wife's support (and 2/3 of each child's support).

h. Did the deceased person have a will?

_____ Yes

_____ No

☑ **Please provide us with a copy of the will.**

i. Do you have a copy of the death certificate?

_____ Yes

_____ No

☑ **Please provide us with a copy of the death certificate.**

j. Was there an autopsy?

_____ Yes

_____ No

☑ **Please provide us with a copy of the autopsy report.**

k. If you do not have a copy of the death certificate, please provide:

i. Date of death:

ii. Place of death:

iii. Cause of death:

iv. Decedent's occupation:

v. Decedent's date of birth:

l. Please provide the name and address of the funeral home, together with a copy of the funeral bill and any other funeral-related expenses (e.g, headstone, flowers, cemetery charges, reception, etc.).

i. Estimate of funeral expenses: $ _____

m. Has anyone been appointed by the Surrogate's Court to represent the estate?

_____ Yes

_____ No

☑ **Please provide us with a copy of the letters of appointment.**

Please sign and date below:

_____
Dated

_____
Name (of individual who completed questionnaire)

_____
Signature:

Exhibit “A”

SUBMISSION CHECKLIST

Have you provided us with copies of the following:

- _____ Health Insurance Cards (e.g., Blue Cross, Aetna, Medicare, Medicaid, etc.)
- _____ Employer benefit summary (if claiming lost income)
- _____ Paystubs (if claiming lost income)
- _____ 5 years of state/federal tax returns (if claiming lost income)
- _____ Photographs of your injuries
- _____ Photographs of the scene of the accident and any Instrumentalities (e.g., car, worksite, product) (if applicable)
- _____ Receipts and/or documentation for out-of-pocket and/or funeral expenses.
- _____ Police accident report (if applicable)
- _____ Death certificate and/or autopsy report (if applicable)
- _____ Letters of Appointment (if applicable)
- _____ Signed digital signature authorization (Exhibit “B”)
- _____ Signed CMS, Workers Compensation, University Hospital, and NYS and IRS tax return authorizations.

Exhibit “B”

DIGITAL SIGNATURE AUTHORIZATION

By signing my name inside the box below I, the undersigned, hereby authorize Bottar Leone, PLLC, to digitize my signature and affix it to necessary legal paperwork, e.g., medical record authorizations, employment authorizations, lien-holder authorizations, discovery responses, etc.

I understand that Bottar Leone, PLLC, will utilize my digital signature without further notice to me.

I understand that I have not authorized Bottar Leone, PLLC, to use (and understand that Bottar Leone, PLLC will not use) my digital signature for any other purpose including, but not limited to, releases, stipulations and/or settlement documents.

_____
Dated

_____
Name (please print)

Signature (must fit inside box)