

MICHAEL L. HAWKINS & ASSOCIATES, P.L.L.C.
MEDICAL MALPRACTICE
CLIENT INTERVIEW QUESTIONNAIRE

420 Ann Street
P.O. Box 595
Frankfort, Kentucky 40602
(502) 223-3459 – phone
(502) 223-2900 – fax
www.mlhlawky.com

I. GENERAL INSTRUCTIONS:

The answers you give on this form are for our use only in the preparation and evaluation of your claim. All answers are confidential; no information will be released to any unauthorized person without your consent. If you so desire, at the conclusion of your case, this interview questionnaire will be returned to you.

Please be candid in answering all questions. Although some questions may ask for personal information, all questions have a legitimate purpose. These questions are aimed at getting the information necessary to prepare your case adequately and professionally. In order to adequately represent your interest, we must know a great deal of information about you, because we cannot afford to be surprised at any stage of the proceedings. Furthermore, we are not the only ones who need to be prepared. You must also be prepared for investigation, discovery, settlement and perhaps even trial. If we have the information we need, we can help prepare you as well.

Although this questionnaire appears to be long and may seem complicated, the questions it asks and answers you will supply are important to your case. Therefore, answer each question as fully and accurately as possible. It is very important that you immediately, upon receipt, take time to complete this questionnaire. Our ability to efficiently process your claim depends upon the information that you supply. If you have any questions, or if anything is unclear or hard to understand, please let us know and we will do our best to assist you.

Finally, please type or print legibly.

IF YOU ARE FILLING OUT THIS FORM ON BEHALF OF SOMEONE ELSE BUT ARE THE PRIMARY CLIENT CONTACT, PLEASE FILL OUT THE NEXT BLOCK OF INFORMATION – IF NOT, PROCEED TO THE NEXT SECTION.

PERSONAL – if you are presenting the claim for someone else:

Full Name: _____ Home Phone: _____

Cell Phone: _____

Home Address: _____
Street Apt # City State Zip

Email: _____

Employer: _____ Work Phone: _____

Work Address: _____
Street City State Zip

MEDICAL MALPRACTICE QUESTIONNAIRE

Your chances of winning and amount of recovery depend upon the accuracy and completeness of your answers. All of your answers are completely confidential and are protected by the attorney-client privilege.

Please use back sheets of questionnaire if more space is needed.

PERSONAL – the person who suffered harm:

Full Name: _____ Home Phone: _____

Cell Phone: _____

Home Address: _____
Street Apt # City State Zip

Email: _____

Employer: _____ Work Phone: _____

Work Address: _____
Street City State Zip

Date of Birth: _____ Social Security # _____

Height: _____ Weight _____ Dominant Hand: _____

Do you Smoke: Yes No How much, How often: _____

Marital Status: Single Married Divorced Widowed

If divorced, from whom, when, and where: _____

List any hobbies you enjoy: _____

Please describe your pre-incident health: _____

EDUCATION:

Please list your entire education background with elementary school through your highest level of education achieved including any vocational or professional training you have had.

Degrees or certificates held:

MILITARY:

Have you ever been rejected for military service because of physical or other reasons?

Yes No

If yes, please explain: _____

Did you ever serve in the military:

Yes No

Branch: _____ Rank: _____

Date Enlisted: _____ Date Discharged: _____ Type of Discharge: _____

Any service-related injuries?: _____

WORK HISTORY:

Employer at time of this claim: _____

Employer Address: _____
Street City State Zip

Job Title: _____ Supervisor: _____

Duties: _____

Rate of Pay: _____ Hours per Week: _____
Before After Before After

Date Job Started: _____ Date Job Ended: _____

Time missed as result of injuries: _____

Did you enjoy your work? _____ Did you feel proud of your work? _____

Has your present employer been understanding of your injuries? _____

Have you received compensation for your injuries? _____

What did you earn in the last year before your injuries? _____

Have you filed federal or state income tax returns for the past five years? _____

Please attach copies to this questionnaire of your returns for the past five years.

Have you attempted to return to work since your injuries? _____

Do you feel you are able to work at your regular job? _____

Do you feel your work is as good as it was before your injuries? _____

Does your employer treat you fairly? _____

Have these injuries changed the way you approach your job? _____

Have you worked as many hours as you usually did prior to the incident or has the amount decreased due to your injuries? _____

Please list any and all employment for the last ten years and include rate of pay, job title, and length employed there:

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

Employer: _____ Address: _____
Length of Time: _____
Rate of Pay (include non-monetary compensation): _____
Brief Description of Duties: _____

MEDICAL HISTORY:

List the names and addresses of **every doctor** who has examined you **for any purpose** in the last **five years**.

*Include employment, insurance, military, or other purposes but **exclude the incident**.

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Please list any prior **hospitals** where you were treated **for any purpose** including emergency room services in the last **five years**.

*Include employment, insurance, military, or other purposes but **exclude the incident**.

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

Name: _____ Address: _____
Approximate Date: _____
Purpose of Examination: _____
Result: _____

List **any pre-existing or prior medical conditions** that you have been diagnosed with:

Are you currently being treated for any of the above? If yes, what treatment?

Please list **any prior surgeries**.

Are you covered by personal health insurance? Yes No

If yes, list insurance company, address, phone, and any group or ID nos. required to identify:

Have you ever been denied any kind of insurance due to your health?

Yes No

If yes, explain in detail: _____

PRIOR ACCIDENTS AND INJURIES:

List here **every** accident you have been involved in or injuries you have sustained. *Failure to tell of other accidents can damage your lawsuit.*

Date: _____ Location: _____

Type of Accident or Injuries: _____

Extent of Injuries: _____

Date: _____ Location: _____

Type of Accident or Injuries: _____

Extent of Injuries: _____

Date: _____ Location: _____

Type of Accident or Injuries: _____

Extent of Injuries: _____

Date: _____ Location: _____

Type of Accident or Injuries: _____

Extent of Injuries: _____

PRIOR CLAIMS AND LAWSUITS:

List every prior claim or lawsuit in which you have been involved. *Failure to tell me of other lawsuits can damage your lawsuit.*

Date: _____ Against Whom? _____
Nature of Claim: _____
Suite Filed? _____ Result: _____

Date: _____ Against Whom? _____
Nature of Claim: _____
Suite Filed? _____ Result: _____

Date: _____ Against Whom? _____
Nature of Claim: _____
Suite Filed? _____ Result: _____

POLICE HISTORY:

List every arrest. *Do not try to hide this information, the other side will find out.*

Date: _____ Place: _____
Charges: _____ Result: _____

Date: _____ Place: _____
Charges: _____ Result: _____

Date: _____ Place: _____
Charges: _____ Result: _____

THE INCIDENT:

Date of Claim: _____ Day of Week: _____

Time: _____ Location: _____

DESCRIPTION OF CLAIM (describe in your own words): _____

Have you given any statements? Yes No

If yes, to whom? _____

Do you have a copy? _____

In your opinion, what could the responsible party have done differently to avoid harm to you?

WITNESSES:

List each and every person who holds information about the claim.

WITNESS 1

Name: _____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Information they have: _____

WITNESS 2

Name: _____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Information they have: _____

WITNESS 3

Name: _____ Phone: _____

Address: _____

Employer: _____ Phone: _____

Information they have: _____

Please use back of questionnaire sheets if more space is needed.

ACTIVITIES:

List any activities or tasks **since the claim** that you have **NOT** been able to perform.

Describe how your injuries have reduced your ability to move any parts of your body (example: walking, bending, lifting, reaching, etc.)

Have you been placed on any restrictions by your physicians?

DAMAGES:

List all portions of your body which were injured:

To the best of your knowledge, did the incident aggravate or worsen any pre-existing physical injury or problem?

As a result of the claim, have you been treated by any physician, or hospitalized in any hospital or medical facility?

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Name: _____ Approx. Date of Treatment _____
Address: _____

Have you received any physical therapy as a result of this incident? _____

Where? (include address) _____

Have you worn a neck collar, neck brace, cast or other type of support prescribed by any one of the physicians? _____

Please use back of questionnaire sheets if more space is needed.

YOUR PAIN:

Where is your pain located? _____

In what part of your body did your pain begin? _____

Is the pain continuous or does it come and go? Please indicate how often and how long it lasts; if it is continuous, describe whether or not it changes.

- Is the pain: rarely present usually present frequent
 always present only under certain circumstances

Is the intensity of the pain always the same or is it sometimes worse? _____

How many times per average day does the pain interfere with your activities? _____

How many times per day do you have to stop what you are doing because of the pain?

What makes your pain worse? _____

Do you feel you are helpless to change your present condition? _____

Have you ever at any time had psychiatric/psychological treatment for any condition? _____
Where and why? _____

In general, are you frequently ill? _____

Do others consider you a sickly person? _____

Does your present condition make you generally miserable? _____

Since your pain condition began, check which people you have consulted for treatment and relief?

- | | |
|---|---|
| <input type="checkbox"/> Allergist | <input type="checkbox"/> Ophthalmologist (eyes) |
| <input type="checkbox"/> Cardiologist (heart) | <input type="checkbox"/> Orthopedist (bones, joints, muscles) |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Clergymen | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Dermatologist (skin) | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Ear, Nose and Throat | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Endocrinologist (glands) | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Radiologist |

- Hypnotist
- Internal medicine
- Neurologist
- Surgeon
- Urologist
- Other: _____

Have your doctors ever told you that your pain was “all in your head?” _____

Have you had any surgeries to help alleviate your pain? _____
 Type of procedure: _____ Did you get relief? _____ For how long? _____

Have you had a nerve block or injections? _____
 Type of procedure: _____ Did you get relief? _____ For how long? _____

List all medications you have taken for pain and dates that you have taken them:

Medication: _____ Dosage: _____ From: _____ To: _____
 Medication: _____ Dosage: _____ From: _____ To: _____
 Medication: _____ Dosage: _____ From: _____ To: _____
 Medication: _____ Dosage: _____ From: _____ To: _____
 Medication: _____ Dosage: _____ From: _____ To: _____

Does the medication bring you any relief? _____

YOUR HABITS:

In general, how well do you sleep? _____

Has this changed since the incident? _____

Does pain wake you at night? _____ How many times? _____

How is your appetite? _____ Any changes due to the incident? _____

Has your pain affected your sex life? _____

YOUR FAMILY:

List the names and relation to you of all persons currently living with you.

If married, how would you describe your marital relationship:

Before Incident:		After Incident:
<input type="checkbox"/>	Very satisfactory	<input type="checkbox"/>
<input type="checkbox"/>	Satisfactory	<input type="checkbox"/>
<input type="checkbox"/>	Tolerable	<input type="checkbox"/>
<input type="checkbox"/>	Intolerable	<input type="checkbox"/>

<input type="checkbox"/>	Minor but persistent problems and conflicts	<input type="checkbox"/>
<input type="checkbox"/>	Major and persistent problems and conflicts	<input type="checkbox"/>

Sources of problems and conflicts

Before Incident:		After Incident:
<input type="checkbox"/>	Finances	<input type="checkbox"/>
<input type="checkbox"/>	Children	<input type="checkbox"/>
<input type="checkbox"/>	Parents/In-laws	<input type="checkbox"/>
<input type="checkbox"/>	Work Situation	<input type="checkbox"/>
<input type="checkbox"/>	Personality Differences	<input type="checkbox"/>
<input type="checkbox"/>	Sexual Difficulties	<input type="checkbox"/>
<input type="checkbox"/>	Illness	<input type="checkbox"/>
<input type="checkbox"/>	House and Environment	<input type="checkbox"/>
<input type="checkbox"/>	Religion	<input type="checkbox"/>
<input type="checkbox"/>	Habits	<input type="checkbox"/>
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

Sources of Income:

- Salary
- Retirement Income/Pension
- Social Security
- Medical/Disability
- Investments
- Child Support
- Other: _____

List your brothers and sisters, their ages and occupations:

What type of work do (did) your parents do? _____

List any family illnesses (heart conditions, diabetes, etc.) and who was affected by it.

Who among these relatives are now deceased? _____

YOUR EMOTIONAL LIFE:

Do you consider yourself to be tense and nervous? _____

What emotional difficulties do you have? _____

Did you have these difficulties in the past? _____

With whom do you regularly discuss your problems? _____

How do you get along with your children? _____

Has this changed due to the incident? _____

How do you get along with your family? _____

Has this changed due to the incident? _____

Do you get angry often? _____ Do you have patience? _____

How often do you get depressed? _____

How often do you cry? _____

Have your injuries made you more irritable or has it taught you more patience? _____

What kind of effects have your injuries had on your social life?

Are you an energetic and active person? _____ Has this changed? _____

SOCIAL ACTIVITIES:

Your desire for social activities can be described as:

Before Incident:		After Incident:
<input type="checkbox"/>	Always	<input type="checkbox"/>
<input type="checkbox"/>	Frequent	<input type="checkbox"/>
<input type="checkbox"/>	Often	<input type="checkbox"/>
<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
<input type="checkbox"/>	Rarely	<input type="checkbox"/>
<input type="checkbox"/>	Never	<input type="checkbox"/>

How has this changed due to your injuries? _____

RECREATIONAL ACTIVITIES:

Your desire for recreation activities can be described as:

Before Incident:		After Incident:
<input type="checkbox"/>	Always	<input type="checkbox"/>
<input type="checkbox"/>	Frequent	<input type="checkbox"/>
<input type="checkbox"/>	Often	<input type="checkbox"/>
<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
<input type="checkbox"/>	Rarely	<input type="checkbox"/>
<input type="checkbox"/>	Never	<input type="checkbox"/>

Has this changed due to your injuries? _____

Restrictions on license? _____

Has your license ever been suspended or revoked? _____

If yes, why? _____

SPOUSE:

Full Name: _____ Home Phone: _____

Cell Phone: _____

Home Address: _____

Street Apt # City State Zip

Employer: _____ Work Phone: _____

Work Address: _____

Street City State Zip

Date of Birth: _____ Social Security # _____

PARENTS:

Mother's Name: _____ Age: _____ Phone #: _____

Address: _____

Father's Name: _____ Age: _____ Phone #: _____

Address: _____

CHILDREN:

List names, ages, addresses, phone numbers, and employers of children and other dependents.

Name: _____ Age: _____ Phone #: _____

Address: _____

Name: _____ Age: _____ Phone #: _____

Address: _____

Name: _____ Age: _____ Phone #: _____

Address: _____

SEXUAL ACTIVITY:

Your desire for sexual activities can be described as:

Before Incident:		After Incident:
<input type="checkbox"/>	Always	<input type="checkbox"/>
<input type="checkbox"/>	Frequent	<input type="checkbox"/>
<input type="checkbox"/>	Often	<input type="checkbox"/>
<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
<input type="checkbox"/>	Rarely	<input type="checkbox"/>
<input type="checkbox"/>	Never	<input type="checkbox"/>

Has this changed due to your injuries? _____

HOBBIES:

Your desire to pursue your hobbies can be described as:

Before Incident:		After Incident:
<input type="checkbox"/>	Always	<input type="checkbox"/>
<input type="checkbox"/>	Frequent	<input type="checkbox"/>
<input type="checkbox"/>	Often	<input type="checkbox"/>
<input type="checkbox"/>	Sometimes	<input type="checkbox"/>
<input type="checkbox"/>	Rarely	<input type="checkbox"/>
<input type="checkbox"/>	Never	<input type="checkbox"/>

Has this changed due to your injuries? How? _____

Is hunting or fishing one of your hobbies? Yes No

IF YES, COMPLETE THE HUNTING AND FISHING QUESTIONNAIRE.

What hobbies have you stopped, due to your injuries? _____
