

**MICHAEL L. HAWKINS & ASSOCIATES, P.L.L.C.**  
**PERSONAL INJURY**  
**CLIENT INTERVIEW QUESTIONNAIRE**

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**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

## PERSONAL INJURY 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.

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Degrees or certificates held:

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**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:

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

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Please list **any prior surgeries**.

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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:

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

Yes             No

If yes, explain in detail: \_\_\_\_\_

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**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.

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

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Have you been placed on any restrictions by your physicians?

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**DAMAGES:**

List all portions of your body which were injured:

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

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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:

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What type of work do (did) your parents do? \_\_\_\_\_

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

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Who among these relatives are now deceased? \_\_\_\_\_

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**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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_