

DOUGLAS, LEONARD & GARVEY, P.C.

**NEW HAMPSHIRE
SPINAL CORD AND NECK INJURY CHECKLIST**

I. General Information

Your Name _____ Date of Birth: _____

Address _____

Home Phone Number _____ Work Phone Number: _____

Marital Status: _____

E-Mail Address: _____

Dependents Yes _____ No _____

<u>Names</u>	<u>Ages</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Social Security Number: _____

Current Employer: _____

Work Address: _____

Length of Time With Employer: _____

II. Your Vehicle Involved in Accident (if applicable)

Year _____ Make _____ Model _____

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Who owned the vehicle? _____

If not your vehicle, did you have permission? _____

III. Your Insurance Company

Name _____

Address _____

Phone _____

Amounts of Bodily Injury Coverage \$ _____

Property Damage \$ _____ Medical Payments \$ _____

Collision \$ _____ Uninsured Motorist \$ _____

Amount of Deductible? \$ _____

Please attach or mail us a copy of your policy.

IV. Details of the Accident

Date of Accident _____

Address/Location of Accident _____

Describe how the accident occurred:

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V. Damages to Vehicles (if applicable)

Describe damage to your vehicle _____

Describe damage to other vehicle _____

Do you have photos of your vehicle? _____

VI. Accident Scene

Did the police respond to the scene? _____

If so, identify the Police Department and police officer _____

Did you give a statement to the police? _____

Have you obtained a copy of the Police Report? _____

Was anyone given a summons or ticket for the accident? _____

Were there any witnesses? _____

If so, identify _____

Did you speak with any witnesses at the scene? _____

If so, describe conversation:

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Did you speak to the driver of the other vehicle? _____

If so, describe conversation:

VII. Other Driver's or Responsible Person's Information

Name _____

Address _____

Insurance Company _____

Make and Model of Vehicle Involved in Accident _____

VIII. Injuries From Accident

Describe your injuries:

Were you taken by ambulance? _____

If so, what hospital were you taken to? _____

If you were not taken by ambulance, when did you first get medical attention? ____

What was your diagnosis? _____

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Were you prescribed any medications? _____

Did you see your primary care physician for accident-related injuries? _____

Identify your primary care physician _____

What medical treatment did you receive from your primary care physician
for accident-related injuries?

Has any medical provider told you that your injuries are permanent? _____

If so, identify the medical provider _____

Provide the date of your last medical treatment for the accident _____

IX. Limitations/Restrictions As a Result of Accident

Describe any limitations or restrictions you have experienced since the accident:

X. Previous Motor Vehicle Accidents

Have you been injured in any previous motor vehicle accidents? _____

Dates of other accidents _____

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Describe previous injuries:

Describe medical attention received for those injuries:

XI. Complete Prior Medical History

In order to investigate your accident case, it is important that we have a complete medical history. This includes all operations, workers' compensation injuries, other injuries or medical problems that you have had in the past including the dates of such injuries or medical problems and the names of all doctors or health care providers who treated you. This remains confidential.

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XII. Criminal History

Please list for our eyes only, all motor vehicle or criminal charges, arrests or convictions you have ever had. If none, say so:

XIII. Economic Losses Following Accident

Did you miss time from work because of accident-related injuries? _____

How many days did you miss from work? _____

Provide the dates you missed from work _____

Date you returned to work _____

Did you get paid while missing work? _____

Did you use sick or vacation time while missing work? _____

Return to:

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