

Michael A. Love, Sr.  
Love-Law  
600 Broadway, Suite 250  
PO Box 410324  
Kansas City, MO 64141-0324  
816-471-4000  
Fax: 816-221-7722  
Email: [mike@love-law.com](mailto:mike@love-law.com)  
Website: [love-law.com](http://love-law.com)

## PERSONAL INJURY QUESTIONNAIRE

### INTRODUCTION

1. Name:

\_\_\_\_\_  
First Middle Last Maiden

2. Date and Place of Birth: \_\_\_\_\_

3. Status. Date and Place of Marriage: \_\_\_\_\_

4. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

5. Social Security Number: \_\_\_\_\_

6. Name of Spouse:

\_\_\_\_\_  
First Middle Last Maiden

7. Date and Place of Birth: \_\_\_\_\_

8. Children:  
Name Date of Birth Place of Birth

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

9. Previous Marriages:  
Name of Spouse Dates Place

\_\_\_\_\_

\_\_\_\_\_

10. Children by/from Previous Marriages:  
Name Date of Birth Place of Birth

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Parents and Familial Background (names, residence, relationship, work history, social/economic background)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. Current Address:  
(Street) \_\_\_\_\_  
(Mailing) \_\_\_\_\_  
(Phone): Home: \_\_\_\_\_ Work: \_\_\_\_\_ (Mobile Phone) \_\_\_\_\_

13. Other Residences for Past Ten Years (from most to least recent):  
Dates \_\_\_\_\_ Street Address. City and State \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Schooling and Years:  
Grade School: \_\_\_\_\_  
Junior High: \_\_\_\_\_  
High School: \_\_\_\_\_ Graduated: \_\_\_\_\_  
College: \_\_\_\_\_  
Other: \_\_\_\_\_

15. Employment During Lifetime:

Dates	Job Title	Company	Salary
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Have you ever had your driver's license picked up, suspended, revoked, or revocation threatened. Also, have you ever been arrested, indicted or convicted of any crime including a felony, misdemeanor or traffic offense. If so, state date, the agency involved *and* for what reasons.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. State if you have ever been involved in a lawsuit, civil or otherwise and identify each action by stating when, where, the nature of the action, the result and name of representing attorney.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FACTS OF ACCIDENT**

18. Date, Day of Week, Time of Day and Weather Conditions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Number of Persons in Auto and Seating Arrangement (indicate on diagram)

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Draw Diagram Below

20. Place of Accident (give directions and draw diagram):

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Draw Diagram Below:





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**INJURIES (For Our Accident)**

30. Set Forth Specific Areas of Body Injured. If onset is later than day of accident, indicate onset date:

Head: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Face (eyes, ears, nose, teeth, etc.): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Neck: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Back (upper, middle, lower, tailbone): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Shoulders & Arms (upper/lower). Elbows, Wrists, Hands, Fingers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chest, Ribs, Abdomen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pelvis, Hips, Buttocks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Legs (upper and lower). Knees, Ankles, Feet, Toes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIOR HEALTH HISTORY (Before Accident)**

31. Pre—Accident General Health History (give specific parts of body that had been previously injured or were causing problems before this accident. Especially note any prior injuries or complaints that correspond with current injuries or complaints).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

32. List all sicknesses or diseases suffered at any time prior to the accident with approximate dates and periods of disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

33. Pre-Accident Health Care Providers Seen in Last Ten Years (Approximate dates and care given including hospitalization and reasons for such confinement. Include any x—rays that have been taken):

Date:	Name of Health Care Provider:	Address:	Care:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____









**WAGE LOSS**

50. Was any time lost from work due to the accident? (If so, list the dates, hours lost, wages and/or lost income and verification):

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51. Job-Related Problems (If problems doing work since accident, describe and obtain names of witnesses who can verify problems):

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52. IRS Returns for Five Years Before Accident if Lost Income or Earning Capacity is at issue:  
Year                      Places of Employment                      Income

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53. Income After Accident:  
Year                      Places of Employment                      Income

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54. Lost Capacity to Work (home or employment and method of verifying such as physical capacities assessment, physician's restrictions etc.):

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**LOSS OF ENJOYMENT OF LIFE**

Set forth activities and/or work enjoyed before the accident and activities and/or work that can't be done or is limited because of injuries.



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60. Effect of Injury on Relationship with Children:

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