



STINSON, LASSWELL & WILSON, L.C.

300 WEST DOUGLAS, SUITE 430

WICHITA, KS 67202

(316) 264-9137 VOICE (316) 264-3791 FAX

WWW.SLWLC.COM

PERSONAL INJURY QUESTIONNAIRE

Name: _____

Any other names you are known by: _____

Address: _____

City, State, Zip: _____

How long at this address: _____

Please list any other addresses and how long you have lived there during the past five years:

Home Phone: (_____) _____ Work Phone: (_____) _____

Fax: (_____) _____ Cell Phone: (_____) _____

Birth Date: _____ Place of Birth: _____

Social Security Number: _____

Driver's License Number (please include state where issued): _____

Father's Name: _____

Address: _____

City, State, Zip: _____

Mother's Name: _____

Address: _____

City, State, Zip: _____

Please list complete history of your education or any other vocational training you have received:

High School: _____

College: _____

Trade School: _____

Other: _____

Degrees: _____

Current Marital Status: Single Married Divorced Widowed

If married, divorced or widowed, please complete for each spouse:

Name of Spouse	Date of Marriage	Place of Marriage	Date of Divorce/Death	Place of Divorce/Death

Current Employer Name: _____
 Address: _____
 City, State, Zip: _____
 Employer's Telephone Number: (_____) _____
 Immediate Supervisor: _____
 How long with current employer? _____
 Current Position: _____ Current Salary: _____

Please State Your Employment History for the Last Five (10) Years:

Place of Employment	Dates of Employment	Immediate Supervisor	Position	Reason for Leaving
1)				
2)				
3)				
4)				

Have you ever been a member of the Armed Forces: Yes No

If so, please complete:

Branch of Service of Which You Were a Member	Dates of Service	Place of Discharge or Separation from Active Duty

Have you ever been convicted of a felony or misdemeanor: Yes No

If so, please complete:

Nature of Offense	Date of Offense	Place of Offense	Date of Conviction

Except for this present claim, have you ever had or made any other claims or suits for injury or disability:

Yes No

(Please include all other claims for personal injury, Worker's Compensation, Social Security Disability or Veterans Benefits)

If so, please complete:

Nature of Claim, Injury or Disability	Date Claim was Filed	Date of Settlement <i>(if any)</i>

Have you at any time before this present claim ever been injured in any manner:

Yes No

If so, please complete:

Claim #1:

Date of Injury: _____

Location of Injury: _____

Circumstances of Injury: _____

Name(s) of Other Parties Involved: _____

Names of All Physicians, Surgeons or other Health Care Providers Who Examined or Treated You: _____

Claim #2:

Date of Injury: _____

Location of Injury: _____

Circumstances of Injury: _____

Name(s) of Other Parties Involved: _____

Names of All Physicians, Surgeons or other Health Care Providers Who Examined or Treated You: _____

Claim #3:

Date of Injury: _____

Location of Injury: _____

Circumstances of Injury: _____

Name(s) of Other Parties Involved: _____

Names of All Physicians, Surgeons or other Health Care Providers Who Examined or Treated You: _____

Claim #4:

Date of Injury: _____

Location of Injury: _____

Circumstances of Injury: _____

Name(s) of Other Parties Involved: _____

Names of All Physicians, Surgeons or other Health Care Providers Who Examined or Treated You: _____

Please state the names of all medical practitioners (including chiropractors) whom examined and/or treated you within the past ten years. Also, list the names of all hospitals and clinics of which you have been a patient in the past ten years:

