



Deborah L. Barron

B a r r i s t e r & S o l i c i t o r

Accident Interview Form

Today's Date: _____

Referred By: _____

Client: _____

Address: _____

_____ Postal Code _____

Date of Birth: _____ Age: _____

Phone: (H) _____ (W) _____ Email: _____

Marital status: _____ Name of spouse: _____

Do you have child(ren)? _____ Child(ren)'s name(s) and birthdates: _____

Date and Time of Accident: _____ am / pm

Employer: _____

Address: _____

Fax: _____ Phone: _____ Postal Code _____

NOTES TO CLIENT:

- 1) PLEASE DO NOT TALK TO WRONGDOER'S ADJUSTERS - INSTEAD, PLEASE REFER THEM TO US.
- 2) YOU MAY BE UNDER SURVEILLANCE - NOTIFY US IF YOU OBSERVE THIS, TO DISCUSS.

SCENE OF ACCIDENT

Location: _____

Weather: _____ Weather: _____ Street Lights: Yes / No

Type and Condition of Road _____

Hill, curve, bridge, etc.: _____

Traffic Lights or Signs _____

Marked Traffic Lanes: _____

Any Charges Laid: _____ Result: _____

List any medications, alcohol or drugs taken by you within 24 hours of the accident (this is confidential):

EVIDENCE

Any admission made or statements signed: _____

Names / Phone Numbers of Witnesses _____

DESCRIPTION OF ACCIDENT

INJURIES

Nature of Injuries: _____

Hospitalized: Yes / No If yes, which hospital and what dates: _____

NAME / FACILITY OF TREATING PRACTITIONERS

Attending Physician: _____

Family Physician: _____

Chiropractor: _____

Physiotherapist: _____

Massage Therapy: _____

Other / Specialists: _____

Other / Specialists: _____

Restriction of Activities: _____

Previous Health and Physical Condition: _____

Previous Injuries: _____

EMPLOYMENT / WAGE LOSS INFORMATION

Will you be advancing a wage loss claim? Yes / No / Don't Know Yet

Dates Absent from Work: _____

Wages / Salary: _____ Full or Part-time: _____

Employment Benefits: _____

Benefit Details: Group Plan No.: _____ I.D No.: _____

SPECIAL DAMAGES (PLEASE FORWARD SUBSTANTIATING RECEIPTS & INVOICES)

Loss of Income or Opportunity to Work _____

Clothing and Personal Articles: _____

Household Help: _____

Taxi / Train / Bus Fares: _____

Out of Pocket Expenses: (i.e. prescriptions, over the counter medications) _____

Other: _____

Please provide: Personal Health Number: _____

Social Insurance Number: _____

Private Health Insurance: _____