LAW OFFICE OF
JEFFREY R. POLLOCK, PLLC.
P.O. Box 399 • Mount Vernon, WA 98273

Jeffrey R. Pollock
ATTORNEY AT LAW
Telephone: (877) 619-0589
Fax: (877) 619-0588

MOTOR VEHICLE ACCIDENT PRE-CONSULTATION FORM

Please complete as much information as possible. If you do not know an answer, you may leave it blank.

1. CLIENT INFORMATION

Full Legal Name:	Date of Birth:
Phone:	Email:
Mailing Address:	
City:	State / ZIP:
Preferred Contact: ☐ Phone ☐ Text ☐ Email	Preferred Language:
Interpreter Needed? ☐ Yes ☐ No	Occupation:
Employer:	Job Title:
Spouses Name: (if married)	

2. ACCIDENT INFORMATION

Date of Accident:	Time of Accident:
City / Location:	County / State:

Type of accident: ☐ Rear-end ☐ Intersection ☐ Head-on ☐ Sideswipe ☐ multi-vehicle ☐ Hit-and-run
☐ Pedestrian ☐ Bicycle ☐ Motorcycle ☐ Rideshare ☐ Commercial vehicle ☐ Other: _____

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐ Motorcyclist Seat belt/helmet used? ☐ Yes ☐ No ☐ N/A

Please describe how the accident happened:

_____

_____

_____

Police responded? ☐ Yes ☐ No Police report made? ☐ Yes ☐ No ☐ Unsure

Police Agency:	Report / Case No.:

Were any citations issued? ☐ Yes ☐ No ☐ Unsure If yes, to whom? _____

Photos/video of scene or vehicles? ☐ Yes ☐ No Dashcam/security footage? ☐ Yes ☐ No ☐ Unsure

Witness names and contact information: _____

_____

3. VEHICLES & OTHER DRIVER

Your Vehicle (year/make/model):	License Plate:
Other Driver #1:	Other Driver #1 Phone:
Other Vehicle #1 (year/make/model):	Other Driver #1 License Plate:
Other Driver #1 Insurance:	Other Driver #1 Policy / Claim No.:
Other Driver #2:	Other Driver #2 Phone:
Other Vehicle #2 (year/make/model):	Other Driver #2 License Plate:
Other Driver #2 Insurance:	Other Driver #2 Policy / Claim No.:
Other Driver #3:	Other Driver #3 Phone:
Other Vehicle #3 (year/make/model):	Other Driver #3 License Plate:
Other Driver #3 Insurance:	Other Driver #3 Policy / Claim No.:

Your Vehicles Condition:

Vehicle damage: ☐ Minor ☐ Moderate ☐ Severe ☐ Total loss ☐ Unsure Airbags deployed? ☐ Yes ☐ No

Vehicle towed? ☐ Yes ☐ No Repair estimate obtained? ☐ Yes ☐ No Property damage resolved? ☐ Yes ☐ No

Where is your vehicle now / repair shop: _____

3. PASSENGER INFORMATION (PASSENGERS IN YOUR VEHICLE AT TIME OF ACCIDENT)

Full Legal Name:	Date of Birth:
Phone:	Email:
Mailing Address:	
City:	State / ZIP:
Full Legal Name:	Date of Birth:
Phone:	Email:
Mailing Address:	
City:	State / ZIP:
Full Legal Name:	Date of Birth:
Phone:	Email:
Mailing Address:	
City:	State / ZIP:

Note: Please add additional sheets if necessary.

4. AUTOMOBILE INSURANCE INFORMATION

Your Auto Insurance Company:	Policy No.:
Your Adjuster:	Claim No.:
Adjuster Phone / Email:	PIP coverage? ☐ Yes ☐ No ☐ Unsure
UM/UIM coverage? ☐ Yes ☐ No ☐ Unsure	MedPay? ☐ Yes ☐ No ☐ Unsure

Have you given a recorded statement to any insurance company? ☐ Yes ☐ No

If yes, which company and when: _____

Have you signed any release, settlement, or authorization? ☐ Yes ☐ No ☐ Unsure

If yes, please explain: _____

5. INJURIES & MEDICAL TREATMENT

Were you transported by ambulance? ☐ Yes ☐ No ER/Urgent Care same day? ☐ Yes ☐ No

Hospital / Clinic:	First Treatment Date:
Primary Treating Provider:	Provider Phone:

Injuries / body parts affected: _____

Symptoms: ☐ Neck ☐ Back ☐ Shoulder ☐ Arm/Hand ☐ Hip ☐ Knee/Leg ☐ Headache ☐ Dizziness
☐ Numbness/Tingling ☐ Concussion symptoms ☐ Anxiety/Sleep problems ☐ Other: _____

Treatment: ☐ X-rays ☐ MRI/CT ☐ PT ☐ Chiropractic ☐ Massage ☐ Injections ☐ Surgery ☐ Counseling

Other treatment / specialists: _____

Future treatment or surgery recommended? ☐ Yes ☐ No If yes what?: _____

Are you still treating? ☐ Yes ☐ No Next appointment: _____

Current physical restrictions or limitations: _____

Are you contending any mental health conditions or injuries associated with your accident? _____

6. PRIOR INJURIES & MEDICAL HISTORY

Before this accident, had you injured or treated the same body part(s)? ☐ Yes ☐ No

If yes, describe injury/treatment and approximate date: _____

Prior motor vehicle accidents? ☐ Yes ☐ No Prior personal injury claims? ☐ Yes ☐ No

If yes, describe approximate dates and injuries: _____

Any subsequent accident or new injury since this collision? ☐ Yes ☐ No

If yes, explain: _____

7. WORK, WAGES & LOST INCOME

Did you miss work because of the accident? ☐ Yes ☐ No

First Day Missed:	Date Returned:
Hourly Wage / Salary:	Average Hours/Week:

Current work status: ☐ Full duty ☐ Light duty ☐ Reduced hours ☐ Off work

Lost wages / income to date (if known): _____

Self-employed? ☐ Yes ☐ No Used PTO/sick/vacation because of accident? ☐ Yes ☐ No Other Income Loss? ☐ Yes ☐ No

8. WORK-RELATED ACCIDENT / L&I

Were you working or performing job duties when the collision occurred? ☐ Yes ☐ No ☐ Unsure

Was a Washington workers' compensation/L&I claim filed? ☐ Yes ☐ No ☐ Unsure

L&I / Self-Insured Claim No.:	Employer:

Receiving time-loss or other workers' compensation benefits? ☐ Yes ☐ No

Workers' compensation attorney, if any: _____

9. EFFECT ON DAILY LIFE

How has the accident affected your normal activities, hobbies, household duties, sleep, or family life?

_____

_____

Do you need help with household or personal activities you previously did yourself? ☐ Yes ☐ No

If yes, who helps and with what: _____

10. HEALTH INSURANCE INFORMATION & MEDICAL BILLS

Health Insurance Primary:	Member ID:
Health Insurance Secondary:	Member ID:

Medicare? ☐ Yes ☐ No Medicaid/Apple Health? ☐ Yes ☐ No VA/TRICARE? ☐ Yes ☐ No Social Security? ☐ Yes ☐ No

Any medical bills in collections or unpaid for this injury? ☐ Yes ☐ No

If yes, please explain: _____

11. ATTORNEYS, CONTACTS & CLAIM STATUS

Have you spoken with or hired another attorney regarding this accident? ☐ Yes ☐ No

Attorney / Law Firm: _____

Have any insurers offered you money to settle your injury claim? ☐ Yes ☐ No

If yes, insurer / amount / date: _____

Has any lawsuit been filed? ☐ Yes ☐ No ☐ Unsure Have you been served with legal papers? ☐ Yes ☐ No

If yes, explain and provide copies: _____

12. WHAT DO YOU NEED HELP WITH?

☐ Medical bills	☐ Ongoing medical treatment
☐ Lost wages	☐ Vehicle/property damage
☐ Insurance communication	☐ Liability dispute
☐ Uninsured/underinsured driver	☐ Hit-and-run claim
☐ Serious/permanent injury	☐ Work-related collision / L&I
☐ Settlement evaluation	☐ Filing a lawsuit
☐ Other: (explain)	

13. ADDITIONAL INFORMATION

What is the most important thing you would like the attorney to know about your accident or injuries?

_____

_____

What would you like our office to help you accomplish?

_____

_14. REFERRAL INFORMATION

How did you hear about our office? ☐ Former Client ☐ Friend/Family ☐ Attorney ☐ Medical Provider
☐ Google/Search ☐ Website ☐ Social Media ☐ Other: _____

Name of person who referred you, if applicable: _____

OFFICE USE ONLY

Date Intake Received:	Appointment Date:
Intake Completed By:	Conflict Check Completed: ☐ Yes

Statute/Deadline Reviewed: ☐ Yes Potential L&I Claim: ☐ Yes ☐ No UM/UIM Issue: ☐ Yes ☐ No
Liability: ☐ Clear ☐ Disputed ☐ Unknown Significant Injury: ☐ Yes ☐ No

Attorney Review / Notes: _____

_____