

January 1, 2011

John Smith  
123 First Street  
Nowhere, NS BON 2T0

Dear Mr. Smith:

**Re: MVA – January 1, 2011  
Claim for Personal Injuries**

Thank you for retaining *(insert name of law firm)* to represent your interests in the above-noted matter. Below you will find a series of questions concerning your personal injury case. Some of the information may not be applicable or you may have already provided it to the lawyer handling your file; however, to ensure that our records are complete, and we have all the necessary information available for easy reference, we would ask you to answer all the questions contained in this letter to the best of your ability and in as much detail as possible.

1. Please provide the following:

- (a) Your full name: \_\_\_\_\_
- (b) Complete address: \_\_\_\_\_  
\_\_\_\_\_
- (c) Phone number: (H) \_\_\_\_\_ (W) \_\_\_\_\_
- (d) Your date of birth: \_\_\_\_\_ Health Card # \_\_\_\_\_
- (e) SIN # *(required for all Loss of Income claims)* \_\_\_\_\_

2. Please provide the names, addresses, and phone numbers of all persons who were with you at the time of the accident.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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3. Were there any other witnesses to the accident? If so, please provide their names, addresses, and phone numbers, if available.

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4. Were you employed at the time of the accident? \_\_\_\_\_

5. What is your occupation? \_\_\_\_\_

6. Where were you employed at the time of the accident? Please provide the name and address of your employer. If possible, please provide the name of a contact person there.

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7. Did you lose any time from work as a result of the accident? How much (Give dates if possible)?

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8. Are you still employed there? \_\_\_\_\_

9. What was your salary/earnings at the time of the accident? Presently?

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10. Have you returned to work? If yes, please indicated the date you returned.

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11. Were you working at the time the accident actually occurred?

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12. Please provide the name and address of your present family doctor. Was this the doctor you had at the time of the accident? How long have you had this family doctor?

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13. Have you ever had any other family doctor(s)? Who? When?

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14. Please provide the names of any other medical doctors, specialists, chiropractors, physiotherapists, or other persons you have seen as a result of your medical condition caused by the accident.

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15. Please generally describe the areas of your body that were injured as a result of the accident.

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16. Did you lose consciousness at the time of the accident? If so, for how long?

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17. Did you have any difficulty remembering the accident? Please explain.

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18. At what time after the accident did you first seek or receive medical attention?

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19. Where did you go for medical attention? Did you see a doctor? If so, who?

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20. What treatment did you receive at that time (i.e. drugs, cast, etc.)?

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21. Are you covered under a Prescription Drug Plan? If so what is the name of the provider?

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22. Are you covered under the Social Assistance Drug Plan?

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23. Have home-care service been provided to you or are they anticipated in the future?

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24. Were you x-rayed? When? Where?

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25. Were you hospitalized? If so, when and for how long? Where?

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26. When did you first become aware of pain after the accident?

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27. When did you first see your family doctor after the accident? What treatment did you receive?

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28. Other than pain, did the accident cause you any other difficulties (i.e. dizziness, nausea, stiffness, etc.)?

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29. What treatment, if any, are you presently receiving? Where do you receive it?

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30. Please provide the location, date, and time of the accident.

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31. What were the weather and road conditions at the time of the accident?

Weather: \_\_\_\_\_

Road: \_\_\_\_\_

32. Do you have private insurance coverage, either through your employer or on your own? If yes, who is the coverage through? What is the policy number?

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

33. Please provide your own, as well as the other driver's license plate numbers and insurance information, if available:

(a) Your license plate #: \_\_\_\_\_ Type of vehicle: \_\_\_\_\_

Year of vehicle: \_\_\_\_\_ Your driver's license #: \_\_\_\_\_

(b) Your insurance company: \_\_\_\_\_

Policy #: \_\_\_\_\_

(c) Other driver's name & address (if known): \_\_\_\_\_  
\_\_\_\_\_

(d) Other driver's license plate #: \_\_\_\_\_ Type of vehicle: \_\_\_\_\_

(e) Other driver's insurance company \_\_\_\_\_

(f) Other driver's policy # and adjuster (if known): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(g) Other driver's license #: \_\_\_\_\_



34. How was your physical condition prior to the accident? Have you ever been injured before in any of the areas you sustained injury as a result of the accident? Please provide details.

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35. Have you ever been involved in any other motor vehicle accidents prior to this accident? If so, when?

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b) If yes, were you injured in the other accident(s)? If yes, what areas of the body?

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36. Please provide a full and complete description of all the events surrounding this current accident (please use additional paper if you feel it is necessary).

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