BEAMENT HEBERT NICHOLSON LLP
TRIAL LAWYERS SINCE 1877
OTTAWA PERSONAL INJURY LAWYERS

Personal Injury Law Experts

The Dispute Resolution Law Firm

979 Wellington St. West
Ottawa, Ontario
Canada K1Y 2X7
Tel: 613-241-3400
Fax: 613-241-8555

Derek Nicholson
Cellular: 613-277-7201
e-mail:dnicholson@beament.com

Internal:

Date: _____

How did client learn of us (i.e. referral, website, etc):

_____

Contingency Fee Agreement: **Yes** ☐ **No** ☐

INITIAL INTERVIEW FORM

PART 1: BACKGROUND CLIENT INFORMATION

Name: _____

Date of Loss: _____
Month / Day / Year

Address: _____

City: _____

Postal Code: _____

Telephone: Home: _____

Business: _____ Cellular:_____

E-mail: _____ Fax No: _____

Date of Birth: _____ OHIP# _____
Month /Day /Year

S.I.N.#: _____

FLA CLAIMANTS (Family Members)

Name	**Date of Birth** **Month /Day /Year**	**Relationship**

(Attach Additional Page if more space required)

PART II: THE INJURY - Description of What Happened?

Date of Loss: _____
Month/Day/Year

Location: _____

_____

_____

_____

_____

BRIEF DESCRIPTION OF ACCIDENT:

_____

_____

_____

_____

Police Report No: _____

Police Dept. _____

Investigating Officer : _____

Officer Badge No: _____

Charges Laid: **Yes ☐** **No ☐**

Witnesses:

Name:_____**Phone No:**_____

Name:_____**Phone No:**_____

PART III: INSURANCE INFORMATION

A) HOMEOWNERS INSURANCE OR OTHER POSSIBLE INSURANCE

_____

Telephone No: _____

Address: _____
(include Postal Code)

INSURER and ANY ADJUSTER OR INSURANCE REPRESENTATIVE OR BROKER YOU HAVE DEALT WITH

Name: _____

Company: _____

Phone No: _____ Policy No: _____

Claim No: _____

Insurance Particulars (policy limits, collision, under-insured, etc.)

_____

_____

_____

_____

PART IV - INJURIES

Injuries Sustained as a Result of this Accident Including any Emotional, Cognitive or other Accident Caused Problems:

_____

_____

_____

_____

_____

_____

_____

Prior Injuries and/or Medical Problems:

_____

_____

_____

_____

_____

_____

_____

_____

PART V - LIST ALL DOCTORS AND HEALTHCARE PROVIDERS WHO HAVE ASSISTED YOU WITH THESE INJURIES AS WELL AS ALL DOCTORS AND HEALTH CARE PROVIDERS YOU HAVE SEEN IN THE LAST 10 YEARS OR EVER IF YOU HAVE HAD SIMILAR PRIOR PROBLEMS

DOCTORS:

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

DOCTORS (Continue if necessary)

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

Name: _____

Speciality: _____

Address (including postal code): _____

Phone No: _____Fax No: _____

OTHER HEALTHCARE PROVIDERS **- (Hospitals, Physiotherapists, Occupational Therapists, etc.)**

Hospital: _____ Phone No: _____

Address (including postal code): _____

Admission: From _____ To _____
Month/Day/Year Month/Day/Year

Hospital: _____ Phone No: _____

Address (including postal code): _____

Admission: From _____ To _____
Month/Day/Year Month/Day/Year

Hospital: _____ Phone No: _____

Address (including postal code): _____

Admission: From _____ To _____
Month/Day/Year Month/Day/Year

Name: _____ Speciality: _____

Company (If Applicable) _____

Address (including postal code): _____

Telephone: _____ Fax No: _____ E-mail: _____

Name: _____ Speciality: _____

Company (If Applicable) _____

Address (including postal code): _____

Telephone: _____ Fax No: _____ E-mail: _____

Name: _____ Speciality: _____

Company (If Applicable) _____

Address (including postal code): _____

Telephone: _____ Fax No: _____ E-mail: _____

PART VI - COMPLETE EMPLOYMENT AND EDUCATIONAL HISTORY

A. COMPLETE EMPLOYMENT HISTORY

Employer: _____ Telephone No: _____

Address (including postal code): _____

Position: _____ Supervisor: _____

Type of Work _____

Length of Employment: _____ Salary: _____

Employer: _____ Telephone No: _____

Address (including postal code): _____

Position: _____ Supervisor: _____

Type of Work _____

Length of Employment: _____ Salary: _____

Employer: _____ Telephone No: _____

Address (including postal code): _____

Position: _____ Supervisor: _____

Type of Work _____

Length of Employment: _____ Salary: _____

Employer: _____ Telephone No: _____

Address (including postal code): _____

Position: _____ Supervisor: _____

Type of Work _____

Length of Employment: _____ Salary: _____

COLLATERAL BENEFITS –

_____

_____

_____

_____

B. COMPLETE EDUCATION HISTORY

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year

Name of School: _____

Address: (Include Postal Code) _____

Telephone: _____ Fax: _____

Period of Attendance: From _____ To: _____
Month/Day/Year Month/Day/Year