Bonar Law Group
1 Centerpointe Dr. Suite #315
La Palma, CA 90623
Telephone: (714) 452-1428
Fax: (714) 452-1418
www.bonarlawgroup.com

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SEVERE INJURY QUESTIONAIRE:

Date of Incident: _____

Your Name:			
Address:			
Telephone #:	Home:	Age / Sex:	**Male / Female**
	Cell:	Marital Status:	
Birth date:		Spouse Name:	
Driver's License #:		S.S. # :	
Email Address:			

Your Opinion About the Incident

Give a brief description of incident Please provide me with your opinion on who was at fault and most importantly, WHY?

DRAW / DIAGRAM OF THE ACCIDENT: ** Use another piece of paper if you prefer

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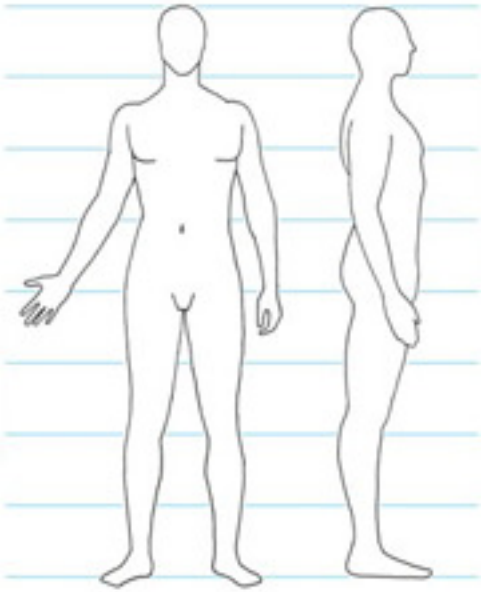
Your Injuries

Please provide pictures of your injuries the day of the incident and pictures AFTER (healing process) -- ***Mark the areas and describe your injuries the day of the incident:***



Your Treatments & Hospitalization &/or Therapy

List all medical care providers, including hospitals, dates of service, ambulance, doctors, x-rays, prescriptions, etc. Give addresses and amounts of bills, if known. If not, just list the name of the doctor and/or provider.

AMBULANCE SERVICE? YES _____ or NO _____	**HOSPITAL or EMERGENCY YES _____ or NO _____**	**DOCTOR / CHIRO /THERAPY TREATMENTS YES _____ or NO _____**
Name of Establishment::	**Name of Establishment::**	**Name of Establishment::**
Address & telephone #:	**Address & telephone #:**	**Address & telephone #:**
Types of service or treatment given:	**Types of service or treatment given:**	**Types of service or treatment given:**
Amount of Bills or Estimate:	**Amount of Bills or Estimate:**	**Amount of Bills or Estimate:**

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*** If you need to add more, please add on a additional piece of paper. Please provide us copies of any bills you receive.

Any surgeries or physical therapy ? If so, please tell us about the procedure and why it was needed:

** **IMPORTANT:** Please submit to us any pictures of your injuries, marks, scrapes, bruises and/or surgical scars. You may email these pictures to your case manager or to our office : **info@bonarlawgroup.com**

Your Losses & How This Affected Your Life

YOUR EMPLOYMENT INFORMATION

Any Loss of Earnings? (missed days from work due to accident?)	**Yes: ( ) No: ( )** Your Occupation: *If you have loss of earnings, please let us know, as we will provide you with an additional form & information you must know in order to claim.*
Employer:	
Address:	
How many days of work did you miss? _____ Will you be claiming for loss of wages? YES or NO You may need to provide pay stubs or a letter from work for your missed hours or any type of proof of loss.	

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Did you lose any earnings due to this accident?	☐ **YES** ☐ **NO** * *Hours lost multiplied by the wage of employee*

Total Hours Lost From Work:	
Total amount lost from work:	**$**

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CURRENT LASTING INJURIES & HOW THIS AFFECTED YOUR LIFE:

(1) Please list down ALL your current pains, defects, injury that is still not healed, pains that you are still feeling and whether or not you feel that you are back to 100% again & why?

HOW THIS AFFECTED YOUR LIFE:

(2) Please describe for me, how this affected your life now. Any physical changes? Marks? Any scars? Any future surgeries? Any lasting trauma?

ANY THOUGHTS OR REMARKS?:

** **IMPORTANT:** Please submit to us any pictures of your injuries, marks, scrapes, bruises and/or surgical scars. You may email these pictures to your case manager or to our office : **info@bonarlawgroup.com**