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Slip, Trip & Fall Intake Sheet

Date: _____

File No.: _____

Referral Source: _____

Client Interviewed By: _____

City/Public Authority Involved? Yes[] No[]

If Yes: State Authority:

Critical Deadlines: _____

NOC Deadline: _____

SOL: _____

I. BACKGROUND INFORMATION

Name: _____

Address: _____

City

State

Zip

Date of Birth: _____ **Social Security number:** _____

Marital status: _____ **Name of spouse:** _____

Spouse's Age: _____ **Spouse's Date of Birth:** _____

Phone Nos.: Home: _____ Business: _____

Cell: _____ Other: _____

Email: _____

II. EMPLOYMENT BACKGROUND

Employer: _____

Work address: _____

City State Zip

What is your present job title? _____

What are your job duties? (Be specific and complete.)

What is your rate of pay? _____

How many hours per week do you work? _____

Were you employed at the time of the accident/incident? _____

Did the accident occur while you were working for your employer?

Yes : _____ No: _____

Did the accident occur while you were at the workplace?

Yes : _____ No: _____

III. SLIP, TRIP & FALL INTAKE SHEET

Day: _____ **Date:** _____

Time: _____ **Weather:** _____

Place where you fell:

Name: _____

Address City Zip

Did you see any warnings, instructions,, or signs giving notice of any dangerous conditions?

Yes: _____ **No:** _____

If yes, please describe

Is there a police report?

Yes: _____ **No:** _____

If yes, please attach a copy

IV. WITNESSES

Witness#1

Name: _____

Address City Zip

Phone Number: _____

Witness#2

Name: _____

Address City Zip

Phone Number: _____

Witness#3

Name: _____

Address _____ City _____ Zip _____

Phone Number: _____

V. MEDICAL CARE

Emergency Care at Scene? Yes: [] No: []

Ambulance: Yes [] No []

Hospital: _____

Injuries: _____

Date Of Treatment: _____ Date Of Discharge: _____

Treatment Type: ER [] Admission []

Outpatient [] Clinic Visit []

List the name, address, and telephone number of each physician, psychiatrist or other medical care provider who has examined, treated or interviewed you relating to your current injuries, and for each one complete the following:

(a) Physician's name _____

Address _____ City _____ Zip _____

Telephone number _____

Date of treatment _____

Treatment prescribed _____

Costs incurred _____

(b) Physician's name _____

Address _____ City _____ Zip _____

Telephone number _____

Date of treatment _____

Treatment prescribed _____

Costs incurred _____

(c) Physician's name _____

Address _____ City _____ Zip _____

Telephone number _____

Date of treatment _____

Treatment prescribed _____

Costs incurred _____

Please list any additional information you have that is not covered in this interview form but which you believe may be of any assistance to us in preparing and evaluating your case.

