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## LAW OFFICES OF BRADLEY J. FRIGON

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### PERSONAL INJURY INTAKE FORM

This form is extremely important. Your accuracy and completeness in responding will assist in our analysis of your case.

#### I. FACTUAL BACKGROUND

1. What is the plaintiff's:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Marital Status: M \_\_\_\_\_ S \_\_\_\_\_

Social security number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

List Claimant's Spouse or Partner and any Minor Children. Provide date of birth for any minor children and indicate if children are from current spouse/partner or a previous marriage or relationship:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Provide date of accident, the nature of the claimant's injury and basis for the lawsuit.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is the claimant mentally competent? YES \_\_\_\_\_ NO \_\_\_\_\_

4. Where does the claimant live (home, public housing, group home, skilled nursing facility)?

\_\_\_\_\_

\_\_\_\_\_.

5. Who is the claimant's primary care provider: \_\_\_\_\_

\_\_\_\_\_

6. U.S. Citizen?            Yes             No

7. Veteran?                Yes             No

8. Is the Claimant represented by an attorney? YES \_\_\_\_\_ NO \_\_\_\_\_. If Yes, identify counsel of record for each party to the lawsuit:

Plaintiff: \_\_\_\_\_

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

Defense: \_\_\_\_\_

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

Attach separate contact information for each attorney of record and identify the party they represent.

9. List contact information for each structured settlement broker involved in the case.

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

**II. MEDICAL DATA**

**1. Health**

Diagnosis \_\_\_\_\_

\_\_\_\_\_

Prognosis \_\_\_\_\_

\_\_\_\_\_

Ongoing Expenses. List anticipated ongoing medical expenses, or attach copy of life care plan.

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2. **Health Insurance**

Is the claimant covered under a health insurance policy? Yes  No

If Yes, attach copy of policy or summary of benefits: If a government or military health insurance coverage just indicate type of plan:

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What are the conditions for continued coverage or when is coverage expected to cease:

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If the claimant is covered under a group health plan, is the claimant's continued coverage under the group plan as a result of a spouse or other family member? Yes  No

If the claimant's coverage is the result of a spouse or other family member, indicate how long the claimant can maintain coverage under the group health plan.

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**III. THE SETTLEMENT**

1. How much is the overall settlement? \_\_\_\_\_.

2. How much has the claimant received prior to the settlement? \_\_\_\_\_.

3. How is the settlement being paid? \_\_\_\_\_

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4. If all or a portion of the settlement is being paid by a structured settlement annuity, provide a summary of the terms of the annuity indicating how much of the annuity payments are guaranteed.

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5. What are the costs? \_\_\_\_\_
6. What is the contingency fee? \_\_\_\_\_
7. Are fees owed to more than one lawyer? YES \_\_\_\_\_ NO \_\_\_\_\_
8. Will there be any attorney liens filed in the case? YES \_\_\_\_\_ NO \_\_\_\_\_
9. Indicate if there are any loss of consortium claims, claims for minors or other derivative claims. \_\_\_\_\_.
10. If all or part of the settlement has been paid to a trust account, provide the date or dates and amounts the settlement was paid.  
\_\_\_\_\_.
11. Indicate if there has been any allocation of damages: \_\_\_\_\_  
\_\_\_\_\_.

**IV. LIENS AND/OR SUBROGATION CLAIMS**

1. Has Medicaid or Medicare been notified of the settlement? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please attach a copy of the notification and any other correspondence.
2. Is there a Medicaid lien or Medicare claim? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please attach a copy of the claim and state if all or part of the lien or claim has been paid.
3. Are there any insurance subrogation claims in the case? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, how much and to whom? \_\_\_\_\_  
\_\_\_\_\_.

**V. PROTECTIVE PROCEEDINGS**

1. Has a conservator, guardian or guardian ad litem been appointed?  
YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, please attach a copy of Order.

**VI. PUBLIC BENEFITS**

1. Is the claimant or **anyone** in the claimant's household or immediate family receiving public benefits? YES \_\_\_\_\_ NO \_\_\_\_\_.

If yes, what public benefits? \_\_\_\_\_

2. Is the claimant eligible for Medicare? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, since when? \_\_\_\_\_

3. If Claimant is not eligible for Medicare, has the claimant filed for SSDI? YES \_\_\_\_\_

NO \_\_\_\_\_. If YES, specify date claimant first received SSDI. \_\_\_\_\_

4. What public benefits is the claimant receiving? (Please list all public benefits; i.e., Medicaid, special waiver programs, SSI, SSDI, Food Stamps, TANF Medicare, etc. and attach Medicaid Card)

\_\_\_\_\_  
\_\_\_\_\_.

5. Is the Claimant currently residing in government subsidized housing? YES \_\_\_\_\_

NO \_\_\_\_\_.

6. Is it likely claimant will require public benefits assistance in the future?

YES \_\_\_\_\_ NO \_\_\_\_\_

7. Does the claimant have any other income? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, from what source? \_\_\_\_\_

8. Does the claimant have any other assets? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please identify? \_\_\_\_\_

9. Has someone made an application for public benefits that is still pending?

YES \_\_\_\_\_ NO \_\_\_\_\_

**VII. MISCELLANEOUS**

1. What does the claimant hope to achieve with this settlement. \_\_\_\_\_

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

2. What kinds of services does the claimant now need that he or she is not receiving? \_\_\_\_\_

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

3. What kinds of equipment or personal property (vehicle, specialized medical equipment, etc) does the Claimant hope to purchase with this settlement?

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4. Does the Claimant want to purchase a home: Yes  No , If Yes, how much is the purchase price, \_\_\_\_\_

5. Do you have any other legal issues which I should be aware of? Yes  No   
If yes, please explain

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**IX. ATTACHMENTS**

If available, please attach copies of the following documents to this form

- (e) Attach copies of all pending applications for public benefits.
- (f) Attach a copy of Medicaid Card or other Public Assistance Identification Card.
- (g) Health Insurance policy or summary of benefits.
- (h) Life Care Plan.
- (i) Rate Age
- (j) A copy of the complaint or demand for damages:
- (k) Proposed Settlement Agreement:

**X. REFERRAL**

By Whom Were You Referred To This Office?

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

NO ATTORNEY CLIENT RELATIONSHIP IS CREATED UNTIL A FEE AGREEMENT IS SIGNED BY THE CLIENT:

**XI. CERTIFICATION**

The undersigned hereby represents to the LAW OFFICES OF BRADLEY J. FRIGON, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Claimant or Claimant's Representative:

\_\_\_\_\_

DATE: \_\_\_\_\_