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Attorney/Client work product – privilege and confidential
CRITICAL CASE INFORMATION SHEET

Dear _____:

The Utah Supreme Court has recently implemented new rules governing cases such as yours. The new rules require all case information to be produced at the outset of litigation. If information is not disclosed at the outset that information may likely be disallowed by the court. Because of these new requirements, we are asking clients to take time to thoroughly complete this form so that we have the critical information needed to prosecute your case and obtain the best settlement for you and your family. We must now more heavily rely on information from you on your case.

I. GENERAL INFORMATION:

Full name: _____
List all other names by which you have ever been known, include aliases, maiden, marital and nicknames:

Address:
_____
Home Phone:
_____
Cell Phone:
_____
Work Phone:
_____
Email:
_____
Date of Birth: _____ Social Security Number: _____

List the addresses where you have resided during the last 10 years. Indicate the period of time at each residence.
Address *Date*
_____
_____
_____
_____
_____
_____

Identify (full names) your spouse, children, and any dependents and their ages:

Name	*Address*	*Age*	*Relationship*

Date of current marriage: _____Place of current marriage: _____

List previous spouses and date of divorce/separation:

Name	*Date*

Identify your media accounts (facebook, myspace, blogspot, twitter, etc.):

_____
_____
_____

II. INCIDENT INFORMATION:

Incident Information:

Date:_____ Weather condition: _____
Location: _____
What police department investigated:

_____
_____

Pictures? _____

Give a brief factual description of the incident: (use back page if needed or separate sheet)

_____
_____
_____
_____
_____
_____
_____
_____
_____

(If an automobile crash) Was your seatbelt on at the time of the crash? ____Yes ____No

(If an automobile crash) Were you a passenger in the vehicle? ___Yes _____No

(If an automobile crash) Did you have passengers in your vehicle? If so, identify them:

Name *Address* *Phone*

Have you given a statement regarding the incident to anyone? _____Yes _____No

If so, who?

Name *Address* *Phone*

Identify witnesses to the incident (if known):

Name *Address* *Phone*

Identify your insurance carrier:

Name *Address* *Phone*

Identify the insurance carrier of the person at fault:

Name *Address* *Phone*

State ALL injuries known to be a result of this incident (Be sure to report all body parts injured to your health care provider):

State present physical condition, including scars, disabilities, deformities, restrictions and discomforts due to the injuries (what problems are you now having?):

_____
_____
_____
_____
_____
_____
_____
_____
_____

How have these injuries impacted your day-to-day life?

_____
_____
_____
_____
_____
_____
_____
_____
_____

List all medical entities with whom/where you have treated for your injuries including doctors, hospitals, clinics, chiropractors, therapists, etc.

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Nature of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

List all pharmacies with whom/where you have filled prescriptions related to your incident injuries

Name and address: _____
Prescription: _____
Still receiving prescription: _____Yes _____No Date last filled: _____

Name and address: _____
Prescription: _____
Still receiving prescription: _____Yes _____No Date last filled: _____

Name and address: _____
Prescription: _____
Still receiving prescription: _____Yes _____No Date last filled: _____

Name and address: _____
Prescription: _____
Still receiving prescription: _____Yes _____No Date last filled: _____

Identify any medical conditions or problems not caused by the incident (that came about either before or since the incident)?

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Identify all prior medical entities (including pharmacies) with whom/where you have treated in the past (whether related to this incident or not):

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Name and address: _____
Purpose of treatment: _____
Still receiving treatment: _____Yes _____No Date of last treatment: _____

Current employment information:

Employer: _____ Occupation: _____
Address: _____
Compensation (hourly or annually): _____ Date Commenced: _____
Numbers of hours a week: _____Number of days worked a week: _____
Supervisor: _____Phone number: _____
Last day worked before incident: _____ Date returned to work: _____
Co-workers: _____
_____

Give a description of your current employment (what you do every day – job duties):

_____
_____
_____
_____
_____
_____

Describe any lost wages you are claiming result from the subject incident (did you miss work, lose wages or benefits?):

_____
_____
_____
_____
_____
_____

Have you had a difficult time doing your daily activities around the house (such as cleaning, laundry, yard work, etc.)? Please provide details as to what you cannot do now that you could before. Also identify anyone who has performed these serves on your behalf and how much you have compensated them:

_____
_____
_____
_____
_____
_____

Describe all money you lost that you are claiming resulted from the incident (provide specific amounts) – these could include out of pocket expenses, medical bills, wages, commissions, job opportunities, etc.:

_____
_____
_____
_____
_____
_____

List your complete past employment history (with years of employment, name of supervisor and whether that supervisor was supportive of you as an employee):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List your academic history (with years of employment, name of supervisor and whether that supervisor was supportive of you as an employee):

_____ _____
_____ _____
_____ _____
_____ _____

Identify any professors or teachers with whom you were particularly close (who could be used as a potential witness on your behalf:

_____
_____
_____

Have you ever been in the military? _____Yes _____ No
Which service? _____ **Dates of service?** _____
Type of discharge? _____ **Are you eligible for VA Benefits?** ____Yes ____ No

Identify any military superiors or other personnel with whom you were particularly close (who could be used as a potential witness on your behalf:

_____
_____
_____
_____
_____

Have you had any service-connected injuries or disabilities? Give details:

Identify your medical/disability insurance (including Social Security Disability, Tricare, Medicaid and Medicare – also include group number, policy number, claim number and any contact information):

Have you ever been charged with a crime involving dishonesty? ____Yes ____ No
If so, provide details and outcome:

Have you ever been involved in another lawsuit? ____Yes ____ No
If so, provide details and outcome:

Have you previously been injured that required medical treatment? ____Yes ____ No
If so, provide details and outcome:

Identify all persons who have information regarding this claim, your injuries and losses and provide a short description of their knowledge:

Name and contact: _____
Description of knowledge: _____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Identify all persons who can support the claims you are making with respect to this matter (these persons as potential witnesses could include family, friends, clergy, business associates, clients, teachers, partners, co-workers, etc.) **and losses and provide a short description of their knowledge:**

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

Name and contact: _____
Description of knowledge: _____
_____

IV. DOCUMENTS NEEDED (items that need to be produced when returning this form):

1. Actual physical evidence (do not alter in any way).
2. Police report or anything given to you by the investigating officers.
3. Correspondence or emails to or from anyone regarding the incident.
4. Health insurance policies, automobile policies or homeowners' policies (whatever is applicable.)
5. Medical bills and medical records.
6. Tax filings for the past 7 years in your possession (personal and business, if applicable)
   If you don't have any in your possession please identify your accountant: _____
   _____
7. Journal/Diary entries relating to incident.
8. Out of pocket expenses and supporting documents and the receipts for verification.
9. Photographs or videos of injuries, during rehabilitation, hospital, incident scene, any physical evidence.
10. Mortuary records including burial and headstone invoices, obituary, funeral documents including announcements, audio or video and photographs.
11. Documentation supporting computation of damages claimed as a result of the incident other than tax records that support your claim for losses.
12. Any documents that support the information given are referenced above