

CLIENT'S PERIODIC REPORT

Client Name:

Date:

D/A:

INSTRUCTIONS:

Enclosed, please find a questionnaire, the answers to which will aid me in keeping your file current. If this is the first such questionnaire I have sent you, please answer each question with complete information from the date of the accident through and including today. Keep a copy of your answers. I will be sending you follow-up questionnaires every couple months. In answering the follow-ups, simply UPDATE the information from the last questionnaire. Your cooperation is necessary to the successful resolution of your case.

Kindly fill out this report and mail it to us promptly. Use the back of the pages, if necessary, making sure to identify the answer with corresponding question number.

1. Since the past report, list all **expenses** you have incurred whether paid or not, as a result of your injuries. (Such as for doctors, hospitals, x-rays, therapy, laboratory, medicine, nursing, household help, crutches, or other expenses you believe should be charges to the accident). Omit items you have previously submitted to our office in this regard.

2. Since the last report, was there anything at work, home or elsewhere, that you found you **could not do** or that you found more difficult to do because of your injuries? YES_____NO_____. If YES, describe:

3. Since the last report, have you suffered any **pains** from your injuries? YES ____ NO _____. If YES, state (a) the location of these pains, (b) how often they occurred, (c) how long they lasted, and (d) whether they were mild, moderate, or severe.

4. Since the last report, did you take any **home treatments**, such as heat, lamp, electric pad, hot water bottle, hot bath, shower, massage, special exercises? YES ____ NO _____. If YES, describe the treatment and how often taken.

5. Since the last report, have you **lost any time from work** because of your injuries? YES ____ NO _____. If YES, give dates missed and wages lost.

6. Since the last report, have you seen a **doctor or physical therapist** because of your injuries? YES ____ NO _____. If YES, state (a) the dates you saw him/her, (b) what was done for you, (c) what he/she told you about your injuries.

7. Since the last report, have you taken any **medicine** for your pain or injuries? YES _____ NO _____. If yes, what did you take and how often?

8. List the names, addresses and telephone numbers of all doctors you have seen who have rendered treatment for your injuries.

9. Are you still treating with any doctors? YES _____ NO _____. If you are still treating, name the doctors and how often you treat.

10. Since the last report, has your **address and/or telephone number changed**? If so, please provide the new address and telephone number.
