CONFIDENTIAL

Medical Negligence Case Evaluation

Medical Malpractice Questionnaire

The answers you give on this form are for our use only in the ***evaluation*** of a potential medical malpractice claim. Although some questions may ask for personal information, all questions have a legitimate purpose. The thorough evaluation of your claim depends upon the accuracy and completeness of your answers.

Name of Medical Malpractice Victim: _____

Victim's Date of Birth: _____

What is your relationship to the victim? Self, spouse, parent, child, friend? _____

Your First Name: _____

Your Last Name: _____

Your Address: _____

Your Phone Number: _____

Your Email Address: _____

Please identify the name of the treating physician(s), medical provider(s), and/or hospital(s) that you feel are responsible for your claim of malpractice:

Please describe the care and treatment that you feel was improper, who provided it, and what it is that your doctor/ hospital did or failed to do in treating you:

INJURIES: Please list all injuries and disabilities you have sustained because of the above incident. If you are able, set forth whether you believe that the injuries will be permanent.

Please share the names and addresses of all medical providers (including hospitals, doctors, chiropractors, physical therapists, etc.) with whom you have treated because of the medical

malpractice. For each medical provider, please set give the following: Name of Provider, Address: Dates of Treatment.

Were you prescribed any medications as a result of the injuries? Yes/No

If you answered 'yes' to the question above, list all medications.

Do you have any appointments scheduled for future medical care? Yes/No

If you answered 'yes' to the question above, please provide detail as to the date, provider, and purpose of the future treatment:

Have you ever been treated for a similar injury or condition in the past? Yes/No

If you answered 'yes' to the question above, please describe these medical providers who have treated you for this type of injury in the past.

As a result of the medical malpractice that may potentially form the basis of a legal claim, have you been (check all that apply):

- ☐ Totally Disabled
- ☐ Partially Disabled
- ☐ Confined To Hospitals
- ☐ Confined To House
- ☐ Confined To Bed

If you checked any boxes in the question above, please give details as to the amount of time of each.

Have you gotten a 2nd opinion? In other words, has any health care provider told you that there was negligence in your care? And if so, who?

Please Check:

- ☐ I understand that the answers given on this form are only for the evaluation of a potential medical malpractice claim. Filling out this form does not create an attorney-client relationship between you and **Davis Law Group**. I understand that **Davis Law Group** will review the information and evaluate the potential claim but may or may not agree to represent me in this matter.

_____ _____

Signature Date

You may mail your completed questionnaire to: Davis Law Group, 2101 Fourth Avenue, Suite 1030, Seattle, WA 98121.

OR, you may fax your completed questionnaire to: 206-727-4001

OR, you may email your completed questionnaire to: info@davislawgroupseattle.com