ECONOMIC LOSS QUESTIONNAIRE
PERSONAL INJURY

CONFIDENTIAL

1) INSTRUCTIONS:

a) Answer each question fully and accurately.

b) Please send the completed forms to:

Gary R. Couillard, CPA
PO Box 709
Brevard, NC 28712

Or, email form as an attachment to an email:
garycouillard@yahoo.com

c) If you have questions regarding the information requested, please call Gary Couillard at (801) 824-5566 during normal business hours.

d) Additional copies of this questionnaire available at garycouillard.com

2) GENERAL INFORMATION:

Attorney's Name: _____

Case Reference: _____ vs. _____

Date Completed Form Sent to Couillard: _____

Form Prepared by _____

Requested Turnaround Time (48 hrs., 1 week, Other)_____

Date of Accident or Injury: _____

3) PERSONAL DATA:

Client's Name: _____Client's Date of Birth: _____

Gender:____ Race (for life expectancy tables) _____

Contact Person: _____ Contact Telephone #: _____

Contact Telephone # _____ Email: _____

Address: _____

4) MARITAL STATUS:

Married Single Divorced

Dates Married: _____ Date Divorced: _____

Name of Spouse: _____ Spouse`s Date of Birth: _____

5) FAMILY BACKGROUND:

Number of Children: _____

List names of all children and dates of birth: _____
_____
_____

Number of people living in home at onset of illness: _____
Names and Relationship _____
_____

Current number of people living in home: _____
Names and Relationship _____
_____

Number of client's grandchildren: _____

6) MILITARY SERVICE:

Branch _____ Years Served __ Type of Discharge _____

7) EDUCATION AND TRAINING:

Circle highest year of education completed and average grade.

Grade School High School College

Year: 1 2 3 4 5 6 7 8 1 2 3 4 1 2 3 4 5 6 7

College Classes and Vocational Training

Name of School:_____
Dates Attended: _____

Years Completed: __ Years Remaining to Degree: _____

Year of Graduation: ___ Degree/Major: _____

8) EMPLOYMENT BACKGROUND INFORMATION:

Provide copies of tax returns for client for 5 years prior to illness or injury.
Complete _____

Provide copies of all tax returns since the illness, injury or death.
Complete _____

Provide copies of all W-2 earning statements, for both the client and spouse, for the requested tax returns. Complete _____

Did client own a business or farm, at any time in the five years prior to the injury?
Explain. _____
** Call me to discuss possible loss of business income.

Did client own any assets or equipment used in his job in the year prior to the onset of the illness or injury ? Explain. _____

Did the client have a second job or help in a family business? Explain. _____
_____

Date of diminished earnings due to illness or injury. _____

Last date of actual work. _____

Provide, if available, payroll check stubs for the last year of work. Complete ___

Did client have any physical or mental limitations that affected his or her ability to perform all responsibilities of his pre-injury job? _____
_____

9) EMPLOYMENT PRIOR TO ILLNESS OR INJURY:

EMPLOYER AT THE TIME OF THE ONSET OF ILLNESS OR INJURY:

Employer _____ Job Title: _____

Address: _____

Beginning Date _____ Ending Date _____

Beginning Salary: _____ End Salary: _____ Hours Worked/Week ____

Last rate of pay: _____ Date of last pay increase: _____

Union Member: yes ____ no _____ Name of Union: _____

Address of Union or Local: _____

List All Promotions in the last five years of employment and dates: _____
_____
_____
_____

If available, provide copy of employee benefit handbook. Complete: _____

If available, provide copy of annual employee benefit statement. Complete: _____

Describe Fringe Benefits. If possible, indicate amount of coverage and amount paid for by client. Describe benefits provided to other family members.

Medical Insurance:_____
Dental Insurance: _____
Short-Term Disability Insurance:_____
Long-Term Disability Insurance:_____
Life Insurance: _____
Car Allowance: _____
401 K Plan: _____
Retirement / Pension Plan: _____
Other Benefits: _____
_____

Have you missed any time from work as a result of your illness or injury (prior to retirement)? If so, list the dates you were unable to work: _____

Did you lose wages for the periods of time that you missed work (prior to retirement) Amounts and Dates:

How much sick leave did you use during your illness or recuperation?

Physical Requirements of Job:

		Explain
Walk:	How Far:	_____
Drive:	How Far:	_____
Stand:	How Long:	_____
Balance:	How Long:	_____
Sit:	How Long:	_____
Carry:	How Much:	_____
Lift:	How Much:	_____
Push:	How Far:	_____
Bend:	How Often:	_____
Pull:	How Far:	_____
Kneel:	How Often:	_____
Stoop:	How Often:	_____
Squat:	How Often:	_____
Handle:	How Often:	_____
Climb:	How Much:	_____
Reach:	How Far:	_____

Was client physically and mentally able to perform the duties of his job prior to the injury or illness? Yes __ No ___

Explain why it is now difficult or why you are unable to perform this job:
_____

Are there specific tasks for your job that you are no longer able to perform without pain? Explain. _____

_____

NEXT PREVIOUS EMPLOYER PRIOR TO ILLNESS OR INJURY:

Employer _____ Job Title: _____
Address: _____
Beginning Date: _____ Date Left: _____ Reason for Leaving: _____
Ending Salary or Rate of Pay: _____

NEXT PREVIOUS EMPLOYER PRIOR TO ILLNESS OR INJURY:

Employer _____ Job Title: _____
Address: _____
Beginning Date: _____ Date Left: _____ Reason for Leaving: _____
Ending Salary or Rate of Pay: _____

10) EMPLOYMENT AFTER ILLNESS OR INJURY:

This section requests information about your employment after the onset of the illness or injury. Begin with your current employer and list all jobs that you have held since the illness or injury. If none, indicate so and skip this section.

CURRENT EMPLOYER:

Employer _____ Job Title: _____
Address: _____
List all promotion or expected promotions and bonuses: _____
_____
_____
_____
Beginning Date: _____ Beginning Rate of Pay _____
Ending Salary or Rate of Pay: _____

NEXT EMPLOYER AFTER ILLNESS OR INJURY:

Employer _____ Job Title: _____
Address: _____
Beginning Date: _____ Date Left: _____ Reason for Leaving: _____
Ending Salary or Rate of Pay: _____

NEXT EMPLOYER AFTER ILLNESS OR INJURY:

Employer _____ Job Title: _____
Address: _____
Beginning Date: _____ Date Left: _____ Reason for Leaving: _____
Ending Salary or Rate of Pay: _____

Did client have any other source of income from outside employment or self-employment activities that produced income after the illness or injury. _____

_____

11) CURRENT EMPLOYEE BENEFITS:

Describe Client's Current Fringe Benefits. If possible, indicate amount of coverage and amount paid for by client. Describe benefits provided to other family members.

Medical Insurance: _____
Dental Insurance: _____
Short-Term Disability Insurance: _____
Long-Term Disability Insurance: _____
Life Insurance: _____
Car Allowance: _____
401 K Plan: _____
Retirement / Pension Plan: _____
Other Benefits: _____

12) SPOUSE'S EMPLOYMENT BEFORE AND AFTER ILLNESS OR INJURY:

Did client's spouse work outside the home prior to the illness or injury? _____

Did client's spouse have an economic need to work outside the home following the client's illness or injury? _____

Did the client's illness or injury reduce the spouse's earnings from outside employment?
_____

13) SOURCES OF INCOME AND BENEFITS:

Provide copy of check stubs showing gross monthly amount received for each source.
Completed ____

14) CURRENT SOURCES OF INCOME:

Source:	Client: Gross Monthly $
Social Security Income	_____
Disability Insurance	_____
VA Benefits	_____
Pension/Retirement	_____
Wages	_____
Other	_____