Attorney Intake Form

Complete all applicable fields. Submit with engagement agreement and signed authorization.

SECTION 1 — LAW FIRM INFORMATION

Law Firm Name	
Street Address	
City, State, ZIP	
Main Phone	
Main Fax	
Firm Website	
Bar Association / State	

SECTION 2 — ATTORNEY OF RECORD

Attorney Full Name	
Direct Phone / Extension	
Direct Email Address	
State Bar Number	
Preferred Contact Method	

SECTION 3 — BILLING CONTACT

Billing Contact Name	
Billing Phone / Email	
Billing Address (if different)	
Purchase Order / Ref. Number	

SECTION 4 — MATTER IDENTIFICATION

Case / Matter Name	
File / Docket Number	
Date of Incident or Injury	

4a. Case Type (select all that apply):

- ☐ Medical Malpractice
- ☐ Personal Injury
- ☐ Workers Compensation
- ☐ Criminal Defense
- ☐ Estate / Probate
- ☐ Other: _____

SECTION 5 — PARTY INFORMATION

5a. Plaintiffs

PLAINTIFF NAME	DATE OF BIRTH

5b. Defendants / Respondents

DEFENDANT / RESPONDENT NAME	FACILITY / ORGANIZATION

SECTION 6 — JURISDICTION

State of Jurisdiction _____

County / Venue _____

Federal or State Court _____

SECTION 7 — CASE STATUS

Select current case status:

☐ Pre-Litigation ☐ Active Litigation ☐ Trial Preparation ☐ Appeal

SECTION 8 — STATUTE OF LIMITATIONS

SOL Date (if known) _____

Any Extensions or Tolling Agreements _____

Note: Consultant is not responsible for monitoring or calculating deadlines.

SECTION 9 — CASE SUMMARY

Provide a brief narrative summary of the case, including key medical events and legal theory of liability:

SECTION 10 — SERVICES REQUESTED

☐ Medical Record Review & Chronology

☐ Standard of Care Analysis

☐ Expert Witness Identification / Referral

☐ Causation Analysis

☐ Deposition / Trial Support

☐ Medical Literature Research

SECTION 11 — MEDICAL SPECIALTIES INVOLVED

☐ Psychiatry / Mental Health
☐ Internal Medicine
☐ Cardiology
☐ Pediatrics
☐ Nursing / Patient Care
☐ Anesthesiology
☐ Emergency Medicine
☐ Surgery (General / Ortho / Neuro)
☐ Obstetrics / Gynecology
☐ Radiology
☐ Pharmacy
☐ Other: _____

SECTION 12 — MEDICAL RECORDS

12a. Have medical records been obtained?

☐ Yes — records enclosed / uploaded
☐ No — authorization attached
☐ Partial — describe below

12b. List record sources / providers obtained (attach list if needed):

SECTION 13 — TURNAROUND TIME

Requested Completion Date _____

Court / Deposition / Trial Date (if set) _____

Note: Rush fees may apply for requests requiring completion within 5 business days.

SECTION 14 — REFERRAL SOURCE

☐ Colleague Referral
☐ Bar Association
☐ Conference / CLE
☐ Online Search
☐ Social Media
☐ Other: _____

SECTION 15 — CONFLICTS OF INTEREST DISCLOSURE

Are you aware of any potential conflicts of interest that should be disclosed to the consultant?

☐ No known conflicts ☐ Yes — describe below

SECTION 16 — CERTIFICATION & SIGNATURE

By signing below, the undersigned certifies that the information provided in this intake form is true, accurate, and complete to the best of their knowledge. The undersigned acknowledges receipt of Anchor Clinical Consulting, PLLC's fee schedule and agrees that submission of this form does not establish a consulting relationship absent a fully executed Consulting Services Agreement.

Signature of Attorney / Authorized Representative

Printed Name

Title / Position

Date

FOR OFFICE USE ONLY

Date Received: Assigned To: Conflict Check: File Opened: