Client Questionnaire

The proper defense of a DWI charge requires a complete medical history which enables your attorney to completely and properly evaluate your case. Most of the scientific and pseudo-scientific evidence in your case rests on assumptions that you are an *"Average Normal Person"* and that you are in *"GoodHealth"*. Therefore, any evidence to the contrary may be useful in your defense.

A complete medical history is also important to help us evaluate your performance on the so-called "Field Sobriety Test(s)" as it may help us present alternative explanations for what may appear to be objective signs of intoxication. The additional personal information requested is confidential and will be used only as necessary to successfully defend your DWI charge.

If a section does not apply to you or you are not comfortable responding, simply leave the section blank.

Thank you for your time and effort in completing this form. It will help us to help you.

PERSONAL INFORMATION:

Name: _____ Eye Color: _____

Age: _____ Date of Birth: _____

Height: _____ Driver's License #_____

Weight: _____ Any other names you have gone by: _____

a. _____

b. _____

CURRENT HOME ADDRES:

Home Phone#: (____)_____may we leave a voicemail message? (Yes) or (No)

Work#: ( )_____ may we leave a voicemail message? (Yes) or (No)

Cell#: ( ) _____ may we leave a voicemail message? (Yes) or (No)

EMPLOYMENT:

ADDRESS_____

_____

PHONE NUMBER_____

JOB TITLE_____

LENGTH OF EMPLOYMENT_____

DUTIES_____

VEHICLE USED IN
EMPLOYMENT?_____

JOB DEPENDENT ON LICENSE? IF YES, DESCRIBE HOW_____

_____

MILES DRIVEN TO AND FROM WORK_____

PRIOR EMPLOYMENT_____

EDUCATION:

HIGH SCHOOL_____

COLLEGE_____

SPECIAL TRAINING_____

FAMILY:

MARRIED/SINGLE/DIVORCED/WIDOWED/ENGAGED_____

SPOUSE'S NAME (MAIDEN INCLUDED)_____

SPOUSE'S EMPLOYMENT_____

DATE MARRIED _____

ACTIVITIES AND TIME SPENT WITH SPOUSE_____

_____

CHILDREN (NAMES & AGES)_____

_____

CHILDRENS' OCCUPATION OR SCHOOL_____

_____

CHILDRENS' MARITAL STATUS_____

_____

CHILDRENS' LOCATION (CITY & STATE)_____

_____

ACTIVITIES AND TIME SPENT WITH CHILDREN_____

_____

MILITARY:

BRANCH_____

DATE OF ENTRY_____

DATE OF DISCHARGE_____

TYPE OF DISCHARGE_____

RANK_____

HONORS & RECOGNITION_____

PHYSICAL CONDITION:

When did you last sleep prior to the offense? _____ how long? _____

Do you have frequent heartburn? _____ Are you being treated? _____

Have you ever been diagnosed with GERD (gastro-esophageal reflux disease)? _____

Do you take Tums, Rolaids, or a prescription medication for heartburn? _____

On the date of the offense, were you taking any medicine of any kind (over the counter or prescription, nutritional supplements, vitamins) Yes / No

If yes list each drug, including cold medicines, antihistamines, and antacids:

drug _____ Last dose prior to stop _____

drug _____ Last dose prior to stop _____

drug _____ Last dose prior to stop _____

Have you EVER had any significant injury to your back, neck, legs, knees, head or other body parts or serious disease, such as emphysema or osteoporosis? Yes / No

If yes state each area injured and any effects that remain:

_____ When _____

_____ When _____

_____ When _____

Please describe your physical condition at the time of the incident: (had cold, allergies, flu, injured, nausea, fever, afraid, etc.)

_____

_____

EYES / HGN:

Do you wear glasses? _____ Contact Lenses? _____

Date of last eye exam? _____

Do you have vision in both eyes? Yes / No

On the day of the incident, did you do anything which would cause eye strain? _____

If yes, please explain: _____

Have you been diagnosed with Eye Muscle Fatigue? _____ If yes, when? _____

Have you been diagnosed with dry eyes? _____ If yes, when? _____

Have you been diagnosed with conjunctivitis? _____ If yes, when? _____

Have you been diagnosed or treated for Glaucoma? _____If yes, when? _____

Do you have a "Lazy Eye" or are you "Cross Eyed"? _____

Are you under the care of an Ophthalmologist? _____

If yes, please provide doctor's:

Name: _____

Address: _____

Phone number: _____

On the day of the incident, had you ingested:

Coffee or soda?	Yes / No	If yes, how much? _____
Tobacco?	Yes / No	If yes, how much? _____
Aspirin?	Yes / No	If yes, how much? _____
Antihistamines?	Yes / No	If yes, how much? _____

On the day of the incident, did you have or, had you suffered from:

Flu?	Yes / No
Cold?	Yes / No
Hypertension?	Yes / No
Hypotension?	Yes / No
Arteriosclerosis?	Yes / No
Streptococcus Infection?	Yes / No
Measles?	Yes / No
Muscular Dystrophy?	Yes / No
Multiple Sclerosis?	Yes / No
Epilepsy?	Yes / No
Brain Hemorrhage?	Yes / No
Inner eye injuries?	Yes / No
Bilateral Amblyopia?	Yes / No
Unusual sleep pattern?	Yes / No
Vertigo?	Yes / No
Dyslexia?	Yes / No

Any other eye problem? Yes / No

EARS/HEARING

Do you wear a hearing aid? Yes / No

Do you have any diagnosed hearing defects? Yes / No

Do you have any diagnosed auditory processing defects? Yes / No

Have you had any inner ear infections? Yes / No If yes, when? _____

Do you suffer from vertigo? Yes / No If yes, how often? _____

Have you suffered any injury to your ears? Yes / No If yes, when? _____

Please describe the injury: _____

Do you get swimmer's ear? Yes / No

BODY TEMPERATURE

What is your normal body temperature? _____

On the day of the incident, was your body temperature higher than normal? Yes / No

If yes, what was your temperature? _____

Within 24 hours of the incident, did you have a fever? Yes / No

If yes, what was your temperature? _____

If you are female, did you have your period or were you pre-menstrual at the time of the incident? Yes / No

LUNGS & RESPIRATORY SYSTEM

Do you have Asthma? Yes / No

Do you have COPD (Chronic Pulmonary Obstructive Disease)? Yes / No

Do you smoke? Yes / No

If yes, how much per day?

Do you have lung cancer? Yes / No

Do you have Lymphoma? Yes / No

Do you have Hodgkins Disease? Yes / No

Do you have throat cancer? Yes / No

Do you have any other diagnosed ailment of the respiratory system? Yes / No

If yes, please describe: _____

On the date of the incident, were you using paint, paint thinner, chemicals of any kind, especially cleaning solvents? Yes / No

If yes, please explain: _____

Do you normally work with or around paints, thinners, or chemicals? Yes/ No

If yes, please explain: _____

Are you diabetic? _____

Do you have a breathing illness such as emphysema? _____

ENDOCRINE SYSTEM

Are you diabetic? Yes / No Type I or Type II? _____

Do you take insulin? Yes / No

If yes, what dose? A.M. _____ P.M. _____

On the day of the incident, were you hypoglycemic or hyperglycemic? Yes / No

If yes, which one? _____

What time? _____

Have you ever had yeast infections? Yes / No

If yes, how often? _____

Were you taking antibiotics on the day of the incident? Yes / No

If yes, what kind? _____

GASTRO-INTESTINAL SYSTEM

Have you been diagnosed with Gastric Reflux Disease? Yes / No

Have you been diagnosed with Esophageal Hernia? Yes / No

Do you suffer from heartburn? Yes / No

Do you use Tagamet, Zantac, or other anti-heartburn medication?

If yes, please list: _____

Do you suffer from urinary tract infections? Yes / No

Do you suffer from bladder infections? Yes / No

SKELETAL SYSTEM

Have you suffered injuries to, or have deformities in your:

Feet?	Yes / No	If yes, describe: _____
Ankles?	Yes / No	If yes, describe: _____
Knees?	Yes / No	If yes, describe: _____
Legs?	Yes / No	If yes, describe: _____
Back?	Yes / No	If yes, describe: _____
Spine?	Yes / No	If yes, describe: _____
Hands?	Yes / No	If yes, describe: _____
Fingers?	Yes / No	If yes, describe: _____
Neck?	Yes / No	If yes, describe: _____

Do you suffer from arthritis? Yes /No If yes, where? _____

Are you "Pigeon Toed"? Yes / No

Are you "Bow Legged"? Yes / No

MUSCULAR SYSTEM

At the time of the incident, did you have any muscle:

Strains?	Yes / No	If yes, where? _____
Sprains?	Yes / No	If yes, where? _____
Tears?	Yes / No	If yes, where? _____
Atrophy?	Yes / No	If yes, where? _____
Cramps?	Yes / No	If yes, where? _____

Have you suffered any disease of the muscles? Yes / No

If yes, please describe:_____

Do you have Ataxia? Yes / No

Do you have any condition which you believe affects your balance and coordination? Yes / No

If yes, please describe: _____

CIRCULATORY SYSTEM

Do you have heart disease? Yes / No

Do you have circulatory problems? Yes / No

Do you take any blood thinners? Yes / No

If so, please list: _____

NEUROLOGICAL / PSYCHOLOGICAL / PSYCHIATRIC

Have you ever suffered a stroke? Yes / No If yes, when? _____

Do you have any partial paralysis? Yes / No If yes, where? _____

Have you ever suffered any injury to the brain? Yes / No

If yes, when? _____ Any lasting effects? Yes / No

Have you ever seen a psychologist or psychiatrist? Yes / No

If yes, when? _____

What was the diagnosis? _____

Were you placed on medication? Yes / No

If yes, please list: _____

Have you been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactive Disorder (ADHD)? Yes / No

If yes, when? _____

Were you placed on medication? Yes / No

If yes, please list: _____

Do you suffer from headaches or migraines? Yes / No

If so, how often? _____

Do you suffer from depression? Yes / No

Do you experience anxiety attacks? Yes / No

Do you get nervous easily? Yes / No

Were you taking medication for any of these at the time of your stop? Yes/No

If yes, please list:_____

ORAL / DENTAL

Do you have periodontal disease?

Do you wear a partial plate or dentures?

Do you have any extensive bridge work?

Do you have any loose caps or crowns?

Do you have any condition which introduces blood into your mouth? Yes / No

If yes, please describe: _____

GENERAL INFORMATION

Do you have any condition which would affect your ability to perform field sobriety tests? Y/N

If yes, please explain:_____

Do you have any condition which might make you appear to be intoxicated? Yes / No

If yes, please explain:_____

Were you sprayed with pepper spray or mace at the time of the incident? Yes / No

ACCIDENT CASES (to be filled out only if you were in an accident)

Did you hit your head? Yes / No

Were you injured in any way? Yes / No

If yes, please explain: _____

Were you wearing a seat belt? Yes / No

Did your air bag deploy? Yes / No

Were you taken to a hospital? Yes / No

If yes, which one? _____

Location of hospital: _____

Were you admitted? Yes / No

Name of attending physician: _____

Were you put on an IV prior to having your blood withdrawn? Yes / No

Do you remember talking with a police officer? Yes / No

Were you ever unconscious? Yes / No If yes, when? _____