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CONFIDENTIAL PRIVILEGED ATTORNEY CLIENT WORK PRODUCT

**FEMA TRAILER FORMALDEHYDE
 CLIENT QUESTIONNAIRE**

You MUST provide medical records associated with FEMA Trailer Formaldehyde exposure.

Information of Injured Party:

Name:					
Address:					
City:		State:		Zip:	
Home Phone:			Cell Phone:		
Work Phone:			Email Address:		
Date of Birth:		Social Security No.		Sex: (M or F)	

If you are completing this form on behalf of a minor or decedent, please complete your information in this section:

Name:					
Address:					
City:		State:		Zip:	
Home Phone:			Cell Phone:		
Work Phone:			Email Address:		
Relationship to Claimant:					

Dates you lived in a FEMA trailer following Hurricane Katrina:

Beginning Date:		Ending Date:	
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Do you still live in a FEMA trailer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Location of FEMA trailer:

Address:					
City:		State:		Zip:	

Please provide the make, model number & manufacturer of your FEMA trailer:

Make:	Model Number:	Manufacturer:
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MEDICAL SECTION

Did you suffer from a medical condition as a result of formaldehyde exposure while residing in a FEMA provided trailer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you diagnosed by a physician for such a condition while residing in a FEMA provided trailer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide medical records as well as the doctor's name and address.		

What was the doctor's diagnosis?	
Date the diagnosis was made:	Month____Day____Year_____
PRIOR to residing in the FEMA trailer did you suffer from this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of any other medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, please explain in the space below:

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Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how much per day?	

Did you obtain any medications or prescriptions or medical bills as a result of exposure to formaldehyde in a FEMA provided trailer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please provide copies of such bills and information

<p>*By signing in the box below, you hereby grant Frank J. D'Amico, Jr., APLC the authority to investigate and access potential confidential information on your behalf</p>

Claimant Signature

Date