Date_____ Referred by_____

Interviewed by_____

CONFIDENTIAL

WORKERS COMPENSATION INFORMATION

Mr./Mrs./Ms.

LAST NAME:_____ FIRST:_____ M.I._____

HOME ADDRESS_____
STREET CITY ZIP CODE

TELEPHONE # home ( )_____ Cell # ( )_____

other ( )_____

E-MAIL:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #: _____- _____-_____

DRIVER'S LIC. # _____ SPOUSE:_____

CHILDREN (Names/DOB) _____

DO YOU HAVE ANY CHILD SUPPORT OBLIGATIONS?? _____

I. EMPLOYMENT * * * * *

EMPLOYER (where you were injured):_____

EMPLOYER'S ADDRESS _____
Street City Zip

EMPLOYER'S PHONE # ( ) _____ SUPERVISOR_____

WORKERS' COMPENSATION INSURANCE _____

INSURANCE CO'S ADDRESS_____
Street City Zip

CLAIM # _____ADJUSTER _____PHONE #_____

DATE(S) OF INJURY: 1._____2._____3._____

DID YOU REPORT THE INJURY(IES) TO EMPLOYER? Yes No

WHEN DID YOU REPORT INJURY(IES)?_____

TO WHOM DID YOU REPORT INJURY(IES)?_____

PART(S) OF BODY INJURED 1. _____

2. _____

3. _____

BRIEFLY DESCRIBE HOW EACH INJURY OCCURRED: (use reverse side, if necessary)

_____

_____

CITY WHERE INJURED_____ TIME OF INJURY_____

OCCUPATION/JOB TITLE(S)_____DATE OF HIRE_____

SUMMARY OF DUTIES_____

LAST DAY WORKED_____ HAVE YOU BEEN TERMINATED?_____

II. MEDICAL CARE

DID YOUR EMPLOYER SEND YOU TO A DOCTOR/ OR CLINIC ? Yes No
Where? _____
When was your first visit? _____ Are you still seeing this doctor? Yes No
When was the last time you saw the company doctor? _____

HAVE YOU SEEN ANY OTHER DOCTORS/CLINICS BECAUSE OF THIS WORK INJURY?
Dr. _____ Date(s) _____
Dr. _____ Date(s) _____
Dr. _____ Date(s) _____
Dr. _____ Date(s) _____

ARE YOU CURRENTLY TREATING FOR YOUR INJURY? Yes No
Who? Dr._____ Last visit: _____

HAVE YOU RECEIVED PHYSICAL THERAPY FOR YOUR INJURY? Yes No
Where? _____
Date therapy started: _____
Date therapy stopped: _____

WHAT MEDICAL PROBLEMS OR COMPLAINTS DO YOU PRESENTLY HAVE THAT YOU FEEL ARE A RESULT OF THE WORK INJURY? _____
_____
_____

HAVE YOU HAD TO PAY ANY OUT-OF-POCKET MONEY FOR MEDICAL TREATMENT, PRESCRIPTIONS, OR EQUIPMENT? Yes NO (Keep your receipts!!!)
$ _____ For: _____
$ _____ For: _____

HAVE YOU SELECTED A SECOND OPINION Q.M.E. DOCTOR FROM A LIST OF 3 DOCTORS SENT TO YOU BY THE STATE? Yes NO
If yes, when was the appointment? _____ Name of doctor? _____

HAVE YOU HAD ANY PRIOR INJURIES ? yes no Explain: _____
_____

PRIOR LAWSUITS? Yes No Explain: _____

HAVE YOU EVER BEEN CONVICTED FOR A FELONY? Yes No _____

III. LOSS OF EARNINGS

Average Weekly Wages (gross) $$_____ Hourly rate of pay $_____

Type of Employment:_____ Permanent

_____ Temporary Date job to end: _____

_____ Seasonal Date season ends: _____

Number of hours per week _____ Average overtime per week _____

How much did you earn the year **prior** to your injury? _____

Did you have a second job at time of injury? YES NO Where? _____

Have you lost time from work due to this injury? _____ If so, state period(s) you were off work:

1) From _____ To _____

2) From _____ To _____

Did you receive compensation? _____ How much per week? $_____ Paid by Insurance Co?_____

Have you received State Disability payments? YES NO

If yes, how much per week $$_____ What period did you receive SDI?

From _____ To _____

Have you applied for State Disability? Yes No

Have you received (or applied for) Unemployment payments? YES NO

If yes, how much per week $$_____ What period did you receive Unemployment?

From _____ To _____

Has any doctor returned you back to work? YES NO Who? _____

Have you returned to work? YES NO

If yes, when did you return to work? _____ Any restrictions given? YES NO

If no, why have you not returned to work?_____

Were you offered your same job back? YES NO

If no, were you offered modified work_____

Same wages? YES NO

HAVE YOU HAD ANY OTHER ON THE JOB INJURIES WITHIN THE LAST 5 YEARS? _____

_____

HAVE YOU HAD ANY PREVIOUS WORKERS' COMPENSATION CLAIMS? YES NO

If yes, When? _____ Part of Body injured? _____

How much did you receive? _____

HOW DID YOU LEARN ABOUT THIS LAW FIRM? _____

DO YOU CURRENTLY HAVE AN ATTORNEY FOR THIS CLAIM ? Yes No

HAVE YOU EVER HAD ANY OTHER ATTORNEY WORK ON THIS CLAIM? Yes No

V. ATTORNEY'S NOTES

Statute of Limitations on possible 3rd party: _____
Discussed/explained SOL to potential client: YES NO
Referred to PI dept/ Refer to another attorney/ Reject 3rd Party case/ Other:

Brief facts on 3rd Party case:

_____

_____

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( ) PANEL Q.M.E. ( ) 132A ( ) S&W ( ) 3RD Party ( ) ADA

MEDICAL:

T.T.D.:

P.D.:

VOC REHAB:

WITNESSES:

Name: _____ Phone # ( ) _____

Address: _____

Name: _____ Phone # ( ) _____

Address: _____

Name: _____ Phone # ( ) _____

Address: _____

Name: _____ Phone # ( ) _____

Address: _____

Name: _____ Phone # ( ) _____

Address: _____

Name: _____ Phone # ( ) _____

Address: _____