Confidential Client Information Sheet for Workers' Compensation

THE FOLLOWING QUESTIONNAIRE HAS BEEN DESIGNED TO PROVIDE US WITH THE INFORMATION NECESSARY TO OBTAIN ALL THE BENEFITS TO WHICH YOU MAY BE ENTITLED. PLEASE ANSWER ALL QUESTIONS. THANK YOU.

Your Full Name: _____ Spouse's Name:_____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell or Pager: _____ Work Phone: _____

Email Address: _____ SS#: _____ DOB: _____

Current Employer: _____ Current Job Title: _____

Do you now have, or ever had an attorney for this claim? ☐ yes ☐ no Who? _____

Do you require an interpreter? ☐ yes ☐ no What language? _____

How did you hear about our office? _____

INJURY

IF YOU HAVE MORE THAN 1 INJURY, LIST THE INFORMATION FOR ALL INJURIES SUSTAINED.

Date of Injury: _____ Location Injury Occurred: _____

Parts of Body Injured: _____

Employer at time of injury: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

Job Title: _____ Date of Hire? _____ Earnings at time of injury: _____ (wk/mo)

Overall Health Condition at Date of Hire: _____

Have you missed work from this injury? yes no From: _____ To: _____ Still off? yes no

How did the injury occur? Over time? yes no Specifics:_____

_____

_____

Did your employer, another employee, or any other person cause your injury? yes no Who? _____

Has a statement/interview taken place between you and the insurance company and/or investigator? yes no

WORKERS' COMPENSATION INSURANCE INFORMATION

Workers' Compensation Carrier: _____ Claim #: _____

Adjuster: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ Zip Code: _____

MEDICAL INFORMATION

Please provide the names and address of the following doctors (if applicable):

Primary Treating Physician: _____

Surgeon: _____

Any other doctors you currently see: _____

List all current medications: _____

MediCal paid treatment? ☐ yes ☐ no MediCare paid treatment? ☐ yes ☐ no Private Insurance paid treatment? ☐ yes ☐ no

Have you had surgery for your injury? ☐ yes ☐ no Is surgery expected? ☐ yes ☐ no

When performed or expected? _____ Type of Surgery? _____

Current symptoms/complaints:

_____

MEDICAL HISTORY

Have you ever had problems with the same body parts injured in this accident? ☐ yes ☐ no

Have you ever filed any other workers' compensation claims? ☐ yes ☐ no

Have you ever had any other claim for injury or damage such as Motor Vehicle Accident? ☐ yes ☐ no

Did you ever have any medical or physical problems at the time of your workers' compensation injury? ☐ yes ☐ no

If you answer yes to any of the above, explain: _____

Are you taking any Medications for Treatment of your workers' compensation injury or any other condition? ☐ yes ☐ no

Please list and describe purpose:

_____

_____

BENEFITS INFORMATION

Since the date of your injury, have you applied for or received any of the following benefits?

Workers' Comp. Temporary Disability:	☐ applied	☐ received	State Disability Benefits:	☐ applied	☐ received
Workers' Comp. Permanent Disability:	☐ applied	☐ received	PERS Retirement:	☐ applied	☐ received
Social Security:	☐ applied	☐ received	Pension/Retirement:	☐ applied	☐ received
Unemployment Benefits:	☐ applied	☐ received	Veterans Benefits:	☐ applied	☐ received

If yes to any above, Weekly rate: $ _____ Date of last check: _____

Still receiving? ☐ yes ☐ no