

**WORKERS' COMPENSATION QUESTIONNAIRE**

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #:( ) \_\_\_\_\_ WORK #:( ) \_\_\_\_\_ CELL #:( ) \_\_\_\_\_

E-MAIL: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_ PH#: \_\_\_\_\_

DO YOU AUTHORIZE YOUR ATTORNEY TO DISCUSS YOUR CASE WITH YOUR SPOUSE?  YES  NO

NAME & PHONE # OF ALTERNATE CONTACT: \_\_\_\_\_

INJURY/ACCIDENT INFO: DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ LOCATION: \_\_\_\_\_

DESCRIPTION OF ACCIDENT/ INJURIES: \_\_\_\_\_

ACCIDENT REPORTED TO EMPLOYER?  YES  NO IF "NO" WHY? \_\_\_\_\_

DATE & TIME REPORTED IF "YES": \_\_\_\_\_

WHERE DID YOU FIRST RECIEVE MEDICAL ATTENTION?: \_\_\_\_\_

DATE: \_\_\_\_\_ DOCTOR'S NAME: \_\_\_\_\_

MEDICAL INFO: TREATING PHYSICIAN (s): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PH #: ( ) \_\_\_\_\_

EMPLOYMENT INFORMATION: EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PH#: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_ WAGE: \_\_\_\_\_

LENGTH OF TIME EMPLOYED: \_\_\_\_\_ LAST DATE WORKED AFTER ACCIDENT: \_\_\_\_\_

**PLACES OF EMPLOYMENT FOR THE LAST YEAR PRIOR TO ACCIDENT/INJURY:**

1.)	2.)
3.)	4.)

**ALL WORKERS' COMPENSATION CLAIMS THAT YOU MAY HAVE:**

<u>CLAIM #:</u>	<u>DATE OF INJURY:</u>	<u>BODY PARTS INJURED:</u>

HAVE YOU HAD PRIOR REPRESENTATION?:  YES  NO If "yes" who? \_\_\_\_\_

ARE YOU CURRENTLY RECEIVING ANY TYPE OF COMPENSATION?  YES  NO If "yes" please list what type(s) of compensation you are receiving: \_\_\_\_\_

Also if "yes" please name the attorney working on your compensation: \_\_\_\_\_

SINCE YOUR ACCIDENT, HAVE YOU PARTICIPATED IN ANY SPORTS OR BECOME INVOLVED IN ANY OTHER ACCIDENTS?  YES  NO

If "yes" please explain: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE?:  INTERNET  PHONEBOOK  BAR ASSOCIATION  PERSONAL REFERENCE \_\_\_\_\_

PROFESSIONAL REFERENCE \_\_\_\_\_

WHAT WOULD YOU LIKE YOUR ATTORNEY TO DO FOR YOU? \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_