

WORKERS COMPENSATION QUESTIONNAIRE

Date _____ Referred to us by: _____

Name _____

Address _____

Home Phone _____ Social Security Number _____

Cell Phone _____ Email _____

Date of Birth _____ Height _____ Weight _____

Dominate Hand (R or L) _____ No. of dependents when injured _____

Spouse's Name _____ Spouse's Date of Birth _____

DESCRIPTION OF YOUR INJURY

Date of Injury _____ Type of Injury _____

Employer when injured _____

Employer's Address _____

Union name and local _____

Job title when injured _____

Wages when injured _____ No. of Hrs. worked per week _____

Employer paid health insurance when injured? (Yes or No)

Date employer payments to health insurance stopped? _____

Describe how the injury occurred: _____

People or Product Causing Injury: _____

Names and addresses of people who witnessed your injury: _____

This form should not be construed to be the formation of a lawyer/client relationship nor a contract for legal representation.

CLAIM INFORMATION

Claim Number _____ Compensation rate _____

Dates compensation paid _____

Reason compensation stopped _____

Compensation agency's name and address: _____

Claims Manager's name & phone number: _____

SOCIAL SECURITY, UNEMPLOYMENT, WELFARE RECEIVED AFTER INJURY

<u>Type of Benefit</u>	<u>Dates Paid</u>	<u>Benefit Rate</u>
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_____	_____	_____
_____	_____	_____

Date of any recent application for benefits? _____

TREATMENT OF INJURY

Present doctor's name: _____

Address: _____

Telephone Number _____

Previous doctor's name: _____

Address: _____

Telephone Number _____

Previous doctor's name: _____

Address: _____

Telephone Number _____

Medical tests, therapies, and surgeries received for injury: _____

Present physical problems: _____

PRIOR INJURIES AND ILLNESS

Date of injury/illness: _____ Type of injury/illness: _____

Doctor's name and address _____

Any claim or suit filed? _____ Settlement _____

Date of injury/illness: _____ Type of injury/illness: _____

Doctor's name and address _____

Any claim or suit filed? _____ Settlement _____

Date of injury/illness: _____ Type of injury/illness: _____

Doctor's name and address _____

Any claim or suit filed? _____ Settlement _____

Date of injury/illness: _____ Type of injury/illness: _____

Doctor's name and address _____

Any claim or suit filed? _____ Settlement _____

EMPLOYMENT HISTORY FOR THE LAST FIVE YEARS

Employer Job Title Employment Dates Highest Wage

EDUCATION

Grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 GED

College completed (circle one) 1 2 3 4 5 6 7 Major _____

Trade school/apprenticeships (circle one) 1 2 3 Program _____

MILITARY SERVICE

Branch _____ Service Disability Percent _____

CIRCLE WORKERS COMPENSATION BENEFITS BEING SOUGHT

(Back TL, Current TL, LEP, PPD, Voc. Rehab., PTD, Medical Treatment)

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