

WORKERS' COMPENSATION INTAKE SHEET

Date: _____

Case Accepted: _____

Referred By: _____

CLIENT INFORMATION:

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

Alternative Telephone: (friend/relative/neighbor) _____

Social Security Number: _____ Date of Birth: _____

Education (Years of School): _____ Height: _____ Weight: _____

Specialized Training or Degrees: _____

Sex: _____ Race: _____

FAMILY INFORMATION:

Married? _____ Spouse Name: _____

Spouse's Employer: _____

Address: _____

Telephone: _____

Dependent Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Pay Child Support? Yes No

Full Time Student: _____

ACCIDENT INFORMATION:

Date of Accident: _____
Location of Accident: _____
Nature of Injured: _____
County Where Injured: _____

DESCRIBE HOW THE ACCIDENT OCCURRED:

EMPLOYER INFORMATION:

Name of Employer: _____
Address: _____
City, State, Zip: _____
Other Employment: _____

COMPENSATION:

Wage Rate (Hourly or Weekly Pay Before Deductions): _____
Overtime (Average Number of Hours Worked Weekly): _____
Compensation Rate (To Be Completed by Attorney): _____
Length of Employment with Employer: _____
Wages from Other Employment: _____
Time Away from Work Due to Accident: _____
Amount of Workers' Compensation Already Paid: _____

DESCRIBE HOW THE ACCIDENT OCCURRED:

Job Title at Time of Accident: _____

Regular Job Duties at Time of Accident: _____

To Whom Was Accident Reported? _____

When Was Accident Reported? _____

INSURANCE INFORMATION:

Employer's Workers' Compensation Carrier (If Known):

Name of Carrier: _____

Carrier Address: _____

City, State, Zip: _____

Adjuster Name: _____

Adjuster Telephone: _____

MEDICAL INFORMATION:

DOCTORS:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____

HOSPITALS:

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____
X-Rays Taken: _____ Surgery? _____ Diagnostic Tests? _____
Date Admitted: _____ Date Discharged? _____

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____
X-Rays Taken: _____ Surgery? _____ Diagnostic Tests? _____
Date Admitted: _____ Date Discharged? _____

EMS of Ambulance Service: _____

WITNESSES TO ACCIDENT:

Name: _____
Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

PRIOR WORKERS' COMPENSATION CLAIMS:

Ever Been Hurt in an Accident Before: _____
If so, when, what, where and how? _____

What Doctors Were Consulted? _____

Previous Attorney Representation? _____

Name, Address and Telephone Number of Attorney: _____

ADDITIONAL COMMENTS:

CRIMINAL RECORD:

No _____ Yes _____

If yes, explain: _____

LAWSUITS, WRECKS, SETTLEMENTS:

No _____ Yes _____

If yes, explain: _____

PSYCHIATRIC/DRUG/ALCOHOL TREATMENT OR REHABILITATION:

No _____ Yes _____

If yes, explain: _____

SOCIAL SECURITY APPLICATIONS FOR DISABILITY:

No _____ Yes _____

If yes, explain: _____

CLIENT EXPECTATIONS:

What problems are you having with this claim? _____

Why have you decided to get an attorney involved?

What do you hope to achieve from retaining counsel?

ATTORNEY COMMENTS:
