WORKER'S COMPENSATION INTERVIEW FORM

Intake Date_________________________ **Referral**_____________________________

Name_______________________________________ **Age**__________________________

Address____

City:________________________ **State:**______________ **Zip:**______________

Telephone: W__________________ **H**____________________ **C**__________________

SS#_____________________________ **DOB**____________________________________

Email ____

Date of Injury____

EMPLOYMENT AT TIME OF INJURY

Job Title____________________________ **Salary**_______________________________

Hours per day and days per week____

Place of Employment____

Address____

Supervisor_____________________________ **Phone Number**_____________________

HOW INJURY OCCURRED:

____
____
____
____
____
____

DESCRIPTION OF INJURIES:

____
____
____
____
____
____

Are you still out of work due to injuries?________________ **Return Date**_________

Has injury been reported to IC?____

By Whom___________________________________ Date_____________________

Ever received any WC Benefits?_________________Amount_________________

WHY ARE YOU SEEKING HELP FROM A LAWYER? (WHAT BENEFITS DO YOU THINK YOU AREN'T GETTING, OR WHAT HAS DEVELOPED IN THE CASE THAT MAKES YOU WANT LEGAL ADVICE?)____

DOCTORS OR MEDICAL FACILITIES CONTACTED/FROM WHOM REFERRAL HAS RECEIVED TREATMENT:

NAME	TYPE OF FACILITY/ PHYSICIAN	ADDRESS/PHONE

Any potential third party liability?_______________________________________

Potential Defendant?____

Any other claims made? Unemployment/ Social Security/ Disability Discrimination

Attorney handling these claims?____

FOR OFFICE USE ONLY
Conflict Check:
By Whom:_______________
Date:____________________