

WORKERS' COMPENSATION INTERVIEW FORM

DATE: _____

Name: _____ (Age) Birthdate: (____) _____

Address: _____ Date of Injury: _____

City: _____ State: _____ Zip: _____ Claim No.: _____

Phone: (home) _____ (work) _____ (message) _____

Social Security #: _____ Spouse's Name _____ Children's ages: _____

Who referred you to our office? _____

How did your injury happen? _____

Is your claim: Open? (Time loss rate) _____ Closed?(date) _____

Rejected?(date) _____ Other Status? _____

Have you missed any time loss compensation?(dates claimed) _____

Describe your disability: _____

Who are your doctors? _____

Hospitalizations/Surgeries(dates): _____

Has the state or employer sent you to any doctors?(when) _____

Do you have medical insurance? (Group #)_____ I.D.# _____

Who has paid your medical bills? _____

Do you owe current or back child support payments? Describe: _____

Employer at time of injury: _____ Since? _____

Job title at time of injury: _____ Date last worked: _____

Wages at time of injury: _____ What other kinds of work have you done? _____

Education: _____ Union Member?(local) _____

Prior industrial injuries?(claim numbers) _____

Disability awards?(dates/percentages) _____

Other significant medical problems? _____

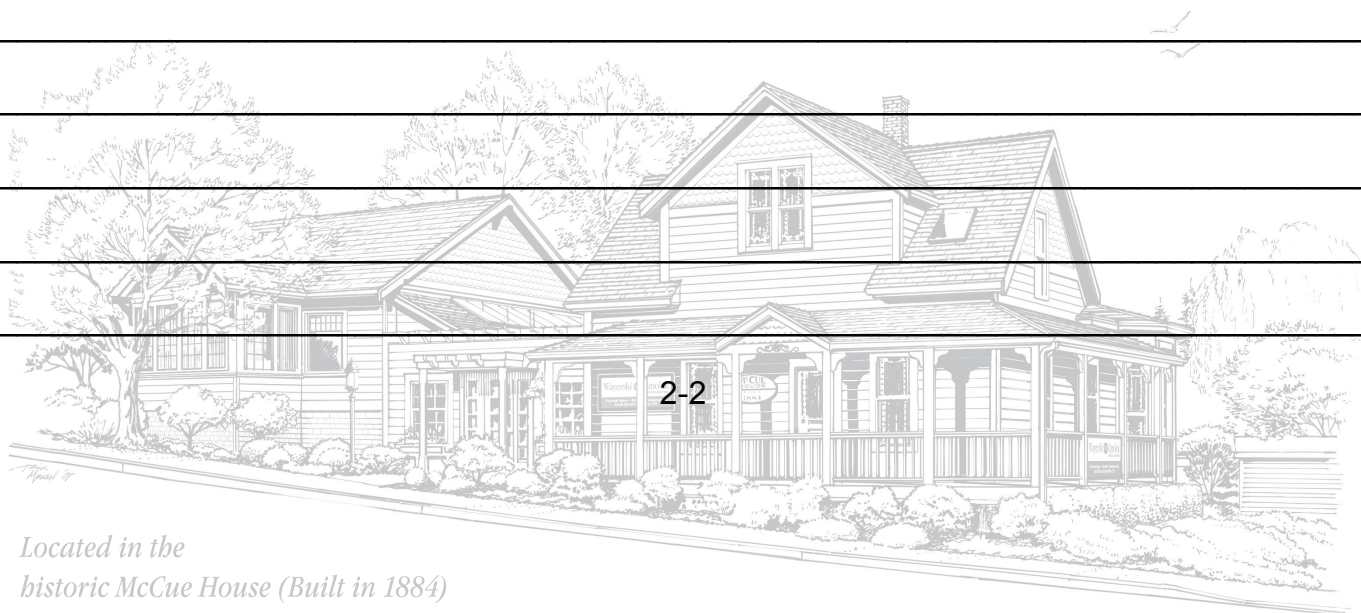
Have you applied for or are you receiving Social Security?(when and result) _____

Since your injury, have you received:

Unemployment?(dates) _____ Public Assistance?(dates) _____

Have you been represented in this claim by other attorneys? _____

Other information which would assist us in evaluating your claim _____



*Located in the
historic McCue House (Built in 1884)*