

WORKERS' COMPENSATION INTERVIEW FORM

DATE: _____

NAME: _____ (AGE) _____ BIRTHDATE: _____

ADDRESS: _____ DATE OF INJURY: _____

CITY: _____ STATE: _____ ZIP: _____ CLAIM NO.: _____

PHONE: (HOME) _____ (CELL): _____ (MESSAGE): _____

EMAIL: _____

SS #: _____ SPOUSE'S NAME: _____ CHILDREN 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 INJURIES: _____

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: _____

WAGE 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?
