

**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\_\_\_\_\_

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