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POTENTIAL CLIENT INTAKE QUESTIONNAIRE

Form revised on 10/30/2019

Name: _____

Complete mailing address: _____

City: _____ State: _____ Zip: _____

Phone number(s): _____ Message Phone: _____

Social Security Number: _____ Birth Date: _____

Who referred you to us: _____

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INJURY

Date of Injury: _____ Part of Body: _____

City or County where injury occurred: _____ Time: _____

How did the injury happen? _____

Claim form (DWC-1) filed with employer: YES _____ NO _____ Date filed: _____

Is the case: Accepted: _____ Delayed: _____ Denied: _____

Employer at time of injury: _____

Employer's address: _____

What was your occupation at the time of injury: _____

Name of Workers' Compensation Insurance Company: _____

Address: _____

What is the phone number for the W/C Carrier: _____

Who is the Adjuster: _____ Phone No.: _____

Claim Number: _____

Earnings: Hourly Rate: _____ How many hours did you work: _____

Did you work overtime? If so, how many hours did you average in a week?_____

Salary amount: _____ Commission:_____ Lodging: _____

Weekly gross earnings on date of injury:_____ (Include overtime)_____

DISABILITY BENEFITS

Dates Workers' Compensation temporary disability payments received:

Rate: $_____ From:_____ To:_____

Dates State Disability payments received:

Rate: $_____ From:_____ To:_____

Dates Unemployment Insurance benefits received:

Rate: $_____ From:_____ To:_____

****

List all employers and dates of employment for the last 12 months prior to the injury: (List the most current employer first, and then work backwards showing the dates). For example: 2010 to 2009 Smith Construction, 2008 to 2007 Jones Recycling, etc.

1.) Year(s)_____ Company:_____

2.) Year(s)_____ Company:_____

3.) Year(s)_____ Company:_____

4.) Year(s)_____ Company:_____

Dates off work due to this injury: From:_____ To:_____

From:_____ To:_____

From:_____ To:_____

From:_____ To:_____

Before your industrial injury, did you get notice of lay-off or termination from your employer:

Yes_____ No_____ If so, date:_____

MEDICAL TREATMENT

Have you seen a Panel Qualified Medical Examiner?: Yes_____ No_____

If Yes, Please list the Name and Address:_____

_____

BRING A COPY OF THE QME REPORT WITH YOU IF YOU HAVE AN APPOINTMENT.

List your Primary Treating Physician:_____

List all Names and Addresses of all doctors who have treated you for your injury:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Who paid the medical bills:_____

Have you designated a treating doctor with your employer: Yes_____ No_____

If so, when:_____

** Did your employer provide health insurance: Yes_____ No_____

Name and address of Health Insurance Company:_____

MEDICAL HISTORY

Have you had any injuries or treatment to this part of body before:

Yes_____ No_____ If so, when:_____

Who treated you:_____

Have you had injuries to other areas of your body: Yes_____ No_____

If so, what parts of your body:_____

When:_____

Is this injury a result of a motor vehicle accident: Yes_____ No_____

If yes, do you have a personal injury attorney:_____

If so, please list the name, address, and telephone number:_____

Did Cal-Osha impose a safety violation or fine your employer as a result of this injury?

Yes_____ No_____

If yes, how much was the fine:_____

Was it considered a Serious Violation: Yes_____ No_____

Why do you feel you need an attorney?

_____

_____

_____

_____

IT IS EXTREMELY IMPORTANT YOU COMPLETE ALL THE ABOVE QUESTIONS.

"Making a false or fraudulent workers' compensation claim is a felony subject to five years in prison or a fine of up to $50,000.00 or double the value of the fraud, whichever is greater, or by imprisonment and fine." [Labor Code Section 5432 (a)]

PLEASE KEEP THIS SHEET AND BRING THESE ITEMS WITH YOU IF AN APPOINTMENT IS SET FOR YOU.
DO NOT SEND THESE ITEMS WITH THE QUESTIONNAIRE

1. Employee's Claim for Workers' Compensation Benefits. (This is Very Important)
2. W-2 forms or other proof of earnings for the last three years.
3. **All** papers received from the Workers' Compensation insurance company.
4. Any medical reports sent to you including your Qualified Medical Examination Report if you have already been evaluated.
5. Any papers received from the Workers' Compensation Appeals Board or the Department of Industrial Relations