



**CLIENT INFORMATION**  
**WORKERS' COMPENSATION**

Date: \_\_\_\_\_

Attorney: \_\_\_\_\_

**I. Referral Information**

How were you referred to our office?      Direct Mail \_\_\_\_\_

Doctor \_\_\_\_\_      Attorney \_\_\_\_\_

Client/Former Client \_\_\_\_\_      Outdoor Ads \_\_\_\_\_

TV      (Brighthouse)      (Verizon Fios)      Other \_\_\_\_\_

Yellow Pages (circle correct ad):	Hernando County -	attorney ad	criminal	W/C
	New Port Richey -	attorney ad	criminal	W/C
	Tarpon Springs -	attorney ad		
	Clearwater -	attorney ad		W/C
	St. Petersburg -	attorney ad	criminal	
	Manatee -	attorney ad		W/C

**II. Client Personal Information**

First, Middle, Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street*
*City*
*State*
*Zip*

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address: \_\_\_\_\_

I am granting permission for the law firm to forward confidential information to me regarding my case via Email. Yes/No

Legal Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Are you a U.S. Citizen? \_\_\_\_\_ If not, what is resident status? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Is injured party a minor?    Yes    No

If minor, name of parent/guardian: \_\_\_\_\_

Name/address/telephone of nearest relative/next of kin: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Are you literate in English?    Yes    No            Are you a high school graduate?    Yes    No

If you are not a high school graduate, GED?    Yes    No            Years of college completed: \_\_\_\_\_

Have you ever been involved in a lawsuit?    Yes    No    If yes, please explain the nature, date, county and state of the lawsuit: \_\_\_\_\_  
\_\_\_\_\_

Married:    Yes    No            If yes, spouse's name: \_\_\_\_\_

Dependents: \_\_\_\_\_

Have you served in the military?    Yes    No    If yes, in what branch did you serve? \_\_\_\_\_

Have you ever been convicted of a felony?    Yes    No            If yes, please state the charge, date, county and state of the charge: \_\_\_\_\_  
\_\_\_\_\_

### **III. Accident and W/C Benefits Information**

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

Where did accident occur? (include city, county and state) \_\_\_\_\_  
\_\_\_\_\_

Description of accident (Were you struck by some object? Did you fall? Did you strain yourself? Were you exposed to some toxic substance or some other job-related disease?)  
\_\_\_\_\_  
\_\_\_\_\_

Description of work being performed when you were injured: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who witnessed the accident? \_\_\_\_\_

Was a third party other than your employer involved?    Yes    No    If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Supervisor: \_\_\_\_\_ Date employer notified of the accident? \_\_\_\_\_

Who was notified of accident? \_\_\_\_\_ District: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Phone: \_\_\_\_\_

Workers' compensation carrier: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City State Zip*

Phone: \_\_\_\_\_ Adjuster: \_\_\_\_\_

What is your current work status according to your treating doctor?(circle) TTD TPD WL PT Since  
what date? \_\_\_\_\_

Date you started missing time from work: \_\_\_\_\_ Date last worked: \_\_\_\_\_

Employment start date: \_\_\_\_\_

Have you received any workers' compensation checks since the accident? Yes No If yes, for  
what period? \_\_\_\_\_

Are you receiving checks now? Yes No If yes, biweekly monthly? If no, when did you  
receive your last check? \_\_\_\_\_ In what amount? \$ \_\_\_\_\_

Has the amount of your check changed since the accident? Yes No If yes, when? \_\_\_\_\_

Are your medical bills being paid? Yes No If no, approximate amount owed: \$ \_\_\_\_\_

Are you receiving reimbursement for mileage? Yes No For prescriptions? Yes No

Are you receiving any of the following:

(a) Unemployment Compensation Yes No  
If yes, for what time periods? \_\_\_\_\_

(b) Social Security Disability Yes No If No, Have you applied for  
SSDI? \_\_\_\_\_ If yes, when did it begin? \_\_\_\_\_ Amount: \$ \_\_\_\_\_

(c) Social Security Retirement Yes No  
If yes, when did it begin? \_\_\_\_\_ Amount: \$ \_\_\_\_\_

(d) Private Insurance benefits Yes No  
If yes, what is the value? \$ \_\_\_\_\_

(e) Medicare/Medicaid Benefits? Yes No  
If yes, amount paid to date: \_\_\_\_\_

(f) Will you be eligible for Medicare benefits within the next five years? \_\_\_\_\_

Have you had any significant medical problems in the past? Yes No If yes, please explain: \_\_\_\_\_

---

---

---

Have you previously been injured in an automobile accident, work-related accident, fall or any other type of accident? Yes No If yes, please provide the following information:

*Date of Accident*      *Type of Accident*      *City/State*      *Injuries*

---

---

---

**IV. Employment Information (for employer at time of accident)**

Job Title/Description/Work Responsibilities: \_\_\_\_\_

---

Earnings on date of accident: \$\_\_\_\_\_ hourly      weekly      monthly      yearly

Number of hours worked per week: \_\_\_\_\_ AWW: \$\_\_\_\_\_ CR: \$\_\_\_\_\_

“Fringe” (health insurance, disability insurance) benefits provided by employer:

---

Amount/value of “fringe” benefits: \_\_\_\_\_ weekly/monthly

Date “fringe” benefits terminated: \_\_\_\_\_ Has your compensation rate been adjusted to include the value of your “fringe” benefits? Yes No

Did you fill out a pre-employment application with the employer? Yes No If yes, were you asked about previous injuries? Yes No If asked, did you reveal prior injuries and claims on the application form? (Martin v. Carpenter \_\_\_\_\_)

Date you started missing time from work : \_\_\_\_\_ Date you last worked: \_\_\_\_\_

Please list your employment history for the past 5 to 10 years:

Employer      Job Title      Date of Employment      Salary

---

---

---



Hospital – Admitted: \_\_\_\_\_

Primary treating physician/Quick Care Facility:  
\_\_\_\_\_

Orthopedist: \_\_\_\_\_

Neurologist: \_\_\_\_\_

Physiatrist (Physical Medicine/Rehabilitation): \_\_\_\_\_

Physical Therapy Facilities: \_\_\_\_\_

MRI/Diagnostic Testing Centers: \_\_\_\_\_

Other: \_\_\_\_\_

Please provide the name, city and state of all physicians with whom you have consulted AND all hospitals where you have been treated, **other than for this accident, within the past ten (10) years:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **VI. Additional Information**

Have you received assistance/benefits through any social service agency as a result of the injuries you sustained in this accident?      Yes      No      If yes, please provide the name of the agency providing such assistance/benefits: \_\_\_\_\_

Do you currently pay or owe past child support?      Yes      No      If yes, answer below:

Are you current in your child support payments? \_\_\_\_\_

County and State where child support owed: \_\_\_\_\_

Amount paid each month currently: \_\_\_\_\_

Current amount of child support arrearage: \_\_\_\_\_

Do you owe past Child Support? \_\_\_\_\_ State: \_\_\_\_\_ Amount: \_\_\_\_\_