



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: _____ AM/PM

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:

<i>Date of Accident</i>	<i>Type of Accident</i>	<i>City/State</i>	<i>Injuries</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

<i>Employer</i>	<i>Job Title</i>	<i>Date of Employment</i>	<i>Salary</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Specific Job Skills Training: _____

Name/address of current employer: _____

Were you working a second job at the time of the accident? Yes/No (This can affect your Average Weekly Wage in determining your wage loss benefits)

If yes, please complete the following:

Second Employer: _____

Address: _____
Street City State Zip

Phone: _____ Supervisor: _____

Earning on date of accident: \$ _____ hourly/weekly/monthly/yearly

Job Title/Description/Work Responsibilities: _____

Employment start date: _____

V. Medical Information

Description of injuries: _____

Has a physician placed you at "maximum medical improvement? (MMI) for the injuries suffered in this accident? Yes/No/Unknown If yes, name of physician: _____ Any percentage of impairment, if known: _____%

Please list any restrictions which your physician has imposed because of your injuries (i.e. lifting, bending, etc): _____

On what date did you last consult with a physician for the injuries sustained in this accident?
_____ Physician: _____

Please list below the name, city and state of all medical providers who have treated or examined you relative to your injuries:

Ambulance: _____

Hospital – Emergency Room only: _____

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: _____