WORKER'S COMPENSATION INTAKE FORM

I. Claimant Information

Today's Date

Full Name:	**Address:**	
SSN:		
DOB:	**Age:**	**Email:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Spouse's Name:	**Spouse's Cell Phone**	
Children (Names & ages):		
Education (formal, trade, on the job, etc.):		

II. Employer

Name:			
Address:			
Date Employment Began:		**Job Title:**	
Still Employed: ☐ **Yes** ☐ **No**	**Work Hours:**	**Overtime:** ☐ **Yes** ☐ **No**	
How Paid: ☐ **Hourly** ☐ **Weekly** ☐ **Bi-weekly** ☐ **Monthly**	**Rate:**_____		
Bonuses: ☐ **Yes** ☐ **No**			

III. Worker's Compensation Insurance Company

Name:	
Phone #:	**Adjuster:**
Claim #:	**Attorney:**

IV. Accident Information

Date:	**Time:**	☐ **A.M.** ☐ **P.M.**
Location of accident / Address:		
General description of the accident:		
Parts of body injured:		
Do you have pictures of your injuries? ☐ **Yes** ☐ **No**		
How client recalls date, time, place (association with landmarks, lunch breaks, etc.)		

V. Notice to Employer

Given to Whom: ☐ **Management** ☐ **Employee**	**Time given:** ☐ **A.M.** ☐ **P.M.**	
Notice given: ☐ **Written** ☐ **Oral**		

VI. Time Lost From Work

How long:
Have you worked since the date of the accident? ☐ **Yes** ☐ **No**
Have you applied for unemployment? ☐ **Yes** ☐ **No**
Have you received cash for labor/services performed since the injury? ☐ **Yes** ☐ **No**

VII. Medical Treatment

Doctor / Hospital:	
Address:	**Phone #:**
Referred By:	**Done treating?** ☐ **Yes** ☐ **No**
Type of treatment received:	
Doctor / Hospital:	
Address:	**Phone #:**
Referred By:	**Done treating?** ☐ **Yes** ☐ **No**
Type of treatment received:	
Doctor / Hospital:	
Address:	**Phone #:**
Referred By:	**Done treating?** ☐ **Yes** ☐ **No**
Type of treatment received:	
Do you have health insurance? ☐ **Yes** ☐ **No** **If yes, name of provider:**	
Do you have Medicare / Medicaid? ☐ **Yes** ☐ **No**	**Do you have Social Security Disability?** ☐ **Yes** ☐ **No**

VIII. Current Complaints

Limitations at work:
Limitations at home:
Recreational limitations:
List the things you can no longer due as well, as often or as quick:

IX. Medical History

Childhood injuries:
Adult injuries:
Primary Care Physician:
List medications taken on a regular basis:

How did you hear about this office?

☐ Personal Referral Name: _____

☐ Radio

☐ Television

☐ Names & Numbers or YellowBook

Other:_____