

INFORMATION SHEET

BACKGROUND

Your Name: _____

Address: _____

Telephone Nos: _____

Date of Birth: _____ SSN: _____

Primary Language: _____ Need Interpreter: _____

Read English?: _____ Write English?: _____

Job Title: _____

Name, address and phone of Employer and the day you were hired: _____

Name, address, and phone of Worker's Compensation Carrier: _____

Name, address, phone and email address of Worker's Compensation Adjustor:

Name, address, phone and email address of each health care provider that you
have seen for your work injury: _____

Name, Address, phone and email address for your family doctor: _____

INJURY

Please describe your job duties: _____

Please describe how you were hurt: _____

Please state the Date of Injury and whether it happened on a specific day or over time: _____

If your injury happened over time, when did you first notice the onset of symptoms: _____

If your injury happened over time, please describe the job duties you believe contributed to your injury: _____

Please identify *any and all* body parts you believe are related to your work injury: _____

Before your injury, did you ever have problems/symptoms/treatment with *any or all* of the body parts involved in your work injury? [Please note that having a pre-existing condition does NOT disqualify you from receiving worker's compensation benefits] If yes, please describe the body part, the problems, symptoms and/or treatment for each body part _____

Who did you tell at work that you were hurt and when did you tell them: _____

If you have missed time from work, when was the last day you performed work for your employer: _____

What were your wages on the day of injury: _____ per _____

Hours worked per week: _____ Overtime: _____

If you have received money since you have been off work, how much are you receiving every two weeks and who is paying it: _____

If you have returned to work, what is the date you did so: _____

Please indicate if you have *ever* had problems with the following conditions:

High blood pressure _____ Hypertension _____ Diabetes _____ Heart _____

Auto-Immune _____ Endocrine system _____ Respiratory _____

Gastrointestinal _____ Kidney _____ Urology _____ Cancer _____

Hearing _____ Vision _____ Neck _____ Back _____ Shoulders _____

Elbows _____ Wrists _____ Hips _____ Knees _____ Ankles _____ Psyche _____

If yes to any above, please describe the problem and when it first started: _____

Please describe *any and all* restrictions on your ability to work that existed *before* your work injury _____

How did you find out about our law firm? _____