WORKMANS COMPENSATION CLIENT INTERVIEW

DATE:_____ REFERRED BY _____

DOES CLIENT SPEAK ENGLISH: (____) YES (____) NO
CLAIMANTS NAME:_____
HOME PHONE:_____ WORK PHONE : _____
SPOUSE/EMERGENCY CONTACT PERSON: _____
ADDRESS:_____
_____
SOCIAL SECURITY # :_____
DATE OF BIRTH:_____AGE:_____
DATE OF ACCIDENT:_____ ACCIDENT REPORTED: (____) YES (____) NO
LOCATION OF ACCIDENT:_____
NAME OF EMPLOYER:_____
ADDRESS:_____
LENGTH OF EMPLOYMENT:_____ COUNTY OF ACCIDENT:_____
DESCRIPTION OF ACCIDENT:_____
_____
_____
_____
INJURIES SUSTAINED:_____
_____
SURGERY (____) YES (____) NO :_____
_____
MEDICAL TREATMENT:_____
_____
_____
DID EMPLOYER SEND CLAIMANT TO DOCTOR? (____) YES (____) NO
WHO?_____
HAS ANY COMPENSATION BEEN PAID TO DATE? (____) YES (____) NO
WHAT TYPE OF BENEFITS: TTD _____ TPD _____ WAGE LOSS _____
AMOUNT OF COMP CHECKS: $ _____
AWW:_____
PRESENT COMPLAINTS:_____
_____
_____
IS CLAIMANT PRESENTLY WORKING? (____) YES (____) NO
ANY PRIOR ACCIDENTS? (____) YES (____) NO : COMP _____
LIABILITY_____
EDUCATION:_____ MILITARY_____
PAST WORK HISTORY:_____
_____
NAME OF INSURANCE CARRIER:_____
ADDRESS:_____
ADJUSTERS NAME:_____ CLAIM # : _____
PHONE # :_____ REMARKS: _____
_____
_____
PRIOR ATTY:_____ADDRESS:_____
DISCHARGED? (____) YES (____) NO
DOES THIRD PARTY APPLY? (____) YES (____) NO

INTERVIEWER: _____ DATE OF INTERVIEW:_____