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WORKERS COMPENSATION INITIAL CLIENT INTERVIEW

I. CLAIMANT INFORMATION

Name	
Social Security	
Telephone Number	
Date of Birth	
Height, Weight, Age	
Name of Spouse, Age	
Name of Relatives, Friends Address	

II. EMPLOYER INFORMATION

Company Name	
Address	
Telephone Number	
Name and Job Title of Your Immediate Supervisor	

III. DETAILS OF INJURY

Date of Injury:_____
Time of Accident:_____
Location of Accident (including County):_____
Compensation Insurance Carrier:_____
If Claimant is other than injured party (deceased), list name and address, age and relationship to injured (deceased) party:_____

Claimant's Description of How Accident Occurred:

Was your accident caused in whole or in part by any use of a piece of defective equipment or machinery? If so explain:

Was your accident caused in whole or in part by carelessness or negligence of persons other than your fellow employees? Is so explain:

IV. WITNESSES TO YOUR ACCIDENT

1. Name	
Address and Telephone Number	
Name of Company Works for	
2. Name	
Address and Telephone Number	
Name of Company Works for	

Have you given a statement regarding your claim to the company, their insurance adjuster, attorney or others? Yes____ No_____

If yes, give details_____
If a time clock used on job, were you punched in? Yes____ No_____
If no time clock on the job, give name of timekeeper and method of keeping employees on job_____

V. NOTICE

Did you give notice of your injury to the company? Yes____ No_____
Name of person to whom you gave notice_____

1. Give details, time, place and witness to whom you gave notice of your injury_____
2. If you did not give notice personally to the company of your injury, state who did. Give details

VI. WAGE INFORMATION

Are your wages paid: Weekly___ Monthly___ Semi-Monthly___ Hourly____
Rate of pay:$_____ per _____
Were you receiving this same rate of pay for at least 13 weeks prior the accident? Yes___ No_____
If you have not worked for the company for 13 weeks prior to the accident, what was the average weekly pay for other employees with your same job classification?_____ per week.
When did you first lose time off your job due to your injury?_____
Are you still of the job due to your injuries as of the date of this report? Yes_____ No_____
If you have returned to work, state the date you returned_____

VII. YOUR INJURIES

State in detail all injuries received as a result of the accident_____
Names and addresses of all treating physicians for this injury

Name	Address
Name	Address
Name	Address

Hospitals and dates of attendance

Name	Attendance
Name	Attendance

What medical treatment have you received in connection with your accident and injury?

As a result of your injury, what kind of physical restrictions has your doctor(s) placed you under?

That you have placed yourself?

VIII. HISTORY

Name all employers which you have ever worked for and how long (give dates)

Describe all the job duties that were involved in the jobs you held in the previously disclosed occupations (e.g., manual labor requiring lifting)

Education level (including occupational training)

Medical-List here all illnesses or accidents you sustained, either before or since your accident

IX. PRIOR ACCIDENTS AND INJURIES

List all prior accidents or injuries (give details)

X. MISCELLANEOUS

Have you been unemployed since your accident?

Have you been fired from your job?

If so, have you sought other employment?

If so, with what results?

Miscellaneous or additional information you feel that is important concerning your claim

Have you ever filed any workers' compensation claim prior to this one, or have you ever drawn workers' compensation benefits? If so, when?

XI. CRIMES

Have you ever been charged with or convicted of a crime? Yes____ No____
If yes, explain

XII. DRINKING HABITS

Nondrinker Yes____ No_____
Drinker Moderate_____ Heavy_____
Have you had any alcoholic beverage when the accident occurred? Yes_____ No_____
If yes, explain

XIII. HEALTH INSURANCE

Have you received any health insurance payments? Yes____ No_____
If so, what company?
Amount of payment
Did you sign any insurance form? Yes_____ No_____

XIV. UNEMPLOYMENT INSURANCE

Have you applied for unemployment insurance? Yes_____ No_____
If so, explain

XV. WORKING RELATIONSHIPS

Relationship between employees and management Good_____ Bad_____
Relationship between you and immediate supervisor Good_____ Bad_____
Relationship among fellow employees Good_____ Bad_____

XVI. WORK CEASED

Did you continue to work after you were injured? Yes_____ No_____

If yes, how long?

XVII. NOTICE

If you not anyone else gave the employer notice, did your supervisor have knowledge that you had been injured? Yes_____ No_____
If yes, explain
Did you inform your supervisor that you were going to consult a physician? Yes___ No____
If yes, explain
Were you physically or mentally unable to give notice? Yes____ No_____
If yes, explain

XVIII. TYPE OF EMPLOYMENT

Did you perform duties away from employer's premises? Yes____ No____
If yes, explain
Had you deviated from your employment from your employment at the time of your injury? Yes____ No____
If yes, explain
Were you on 24-hour call? Yes____ No____
Did employer furnish you a vehicle or travel expenses? Yes____ No____

XIX. DISABILITY

Was your disability caused from mental rather than physical impairment? Yes____ No____
If yes, explain
Have you had any previous mental problems? Yes____ No____
If yes, explain

XX. MARITAL STATUS

Are you divorced or separated? Yes____ No____
If yes, explain
Are you living with anyone you are not married to? Yes___ No_____
If yes, state full name

XXI. FINANCIAL STATUS

Have you discussed this claim with any other attorney? Yes___ No____
If yes, explain

Thank you for completing our questionnaire so that we may be able to better assist you! Once completed please send to us via email at support@galegalpro.com or help@galegalpro.com

Once submitted, our attorney will contact you to set up a follow up appointment to discuss your case in detail.