CLIENT INFORMATION SHEET

Name_____Address_____
_____
_____
Phone: (H)_____(Cell)_____ Email_____

Social Security Number_____ Date of Birth_____

Name of Spouse_____

EMPLOYMENT ON DATE OF INJURY:

Employer_____ Address_____

Employer Phone Number:_____

Name of Immediate Supervisor:_____

Date of Accident:_____

City/County of Accident:_____

What was your job?_____Length of Employment:_____

Rate of Pay:_____ What was your pay before deductions?_____

Are you still employed by this Employer?_____

If still employed are you willing to resign from your job?_____

Did you have a second job at the time of this accident?_____If you did, provide:

Name and address of second employer_____

WORKERS COMP INSURANCE COMPANY

Name of your Employer's workers compensation insurance company:_____

Name and phone number of any claims person who has contacted you:
_____

Are you receiving weekly checks for being out of work?_____If so, how much:_____

YOUR ACCIDENT

How were you hurt?_____

Were there any witnesses?_____If so, list their names:_____

Did your Employer send you for treatment?_____

Where did you receive your first treatment?_____

Name of doctor treating you now_____

Did you have to stop work due to your injuries?_____

If so, when was the last day that you worked?_____

Did a doctor authorize you to be out of work?_____ If so, which doctor?_____

Were you released to work with some restrictions?_____If so, what restrictions?_____

Have you returned to work?_____Date you returned:_____

OTHER INFORMATION:

Do you have any outstanding child support lien?_____

Do you have a personal injury claim going as a result of this accident?_____

How did you find out about me?_____