Whiteman, Hamilton & Conklin, LLC

Claimant Intake Sheet

Today's Date:

1. Name:

_____

2. Address:

_____

_____

_____

3. Phone Number (home):

_____

4. Phone Number (mobile):

_____

5. Social Security Number: **Date of Birth:**

_____

6. Name and Full Mailing Address of Employer and provide County of accident:

_____

_____

_____

_____

7. Name of Workers' Compensation Insurer or Servicing Agent and Name and contact info of Insurance adjuster (provide both):

_____

_____

8. Date(s) of Accident and Body Part(s) Affected:

_____

_____

_____

9. Brief Description of Accident:

_____

_____

_____

10. Whether There Were Three or More Employees Working for Employer:

Yes No

11. Name, address and telephone numbers of all places where you sought medical treatment:

_____

_____

_____

12. Are you currently working? ____ Yes ____ No. If no, when was the last day you worked and why did you stop working? If terminated provide date of termination and attach separation notice.

_____

_____

_____

13. Are you currently represented or have you had an attorney previously for this work-related injury?

_____

_____

14. Is your Employer paying for or have they provided any medical treatment? If so, please specify:

_____

_____

_____

_____

15. Date of Hire with Employer: _____

16. Are you still employed with Employer: ____ Yes ___ No

17. Are you currently receiving a weekly check from the Workers' Compensation Insurer?

___ Yes ___ No

If yes, what is the weekly amount?

18. Did your Employer require you to take a drug test after the accident?

____ Yes ____ No

If yes, provide the date and time of drug test:_____

the facility's name that did the test:_____

the results of the test:_____

Please attach a full and complete copy of any drug test result/report.

19. Email address:

_____

20. Have you ever been hurt on a job before? _____ Yes _____ No

21. Have you ever filed a workers' compensation before? _____ Yes _____ No

22. What was your hourly wage for the Employer? $_____/hour.
How may hours per week did you average? _____/hours.

23. Please provide the name, address and dates of service for all medical providers who provided treatment/evaluation for the work-related injury(s). Please attach a full and complete copy of all medical records to this form.

24. If you returned to work for a different employer after the accident, please attach a copy of your last paystub from each subsequent employer. Also please provide below the name, address, and rate of pay for each subsequent employer below and the dates of employment:

26. Have you ever been involved in a car accident before? _____ Yes _____ No

Please describe the details of the accident (s) in terms of what happened, when it happened, where it happened, and whether the case settled and for how much.

Additional Comments or Notes:

Please obtain and provide to our firm all medical records, including activity status sheets, referrals and office narrative visit notes for any treatment you have received since the date of accident.