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WORKERS' COMPENSATION INJURY QUESTIONNAIRE

STATEMENT OF CONFIDENTIALITY: This is a confidential questionnaire for the use of the offices of Chesley, Kroon, Harvey & Carpenter in preparing your claim for personal injuries. The information you provide to us will not be released, and will be held strictly confidential. Please answer every question fully and accurately, because, as your attorneys, we must know all the facts of your case.

CLIENT OVERVIEW

Your name: _____

Address: _____

Telephone: (H)(_____) _____

(W)(_____) _____

(Cell)(_____) _____

E-Mail: _____

Who referred you to us? _____

PERSONAL DATA

Birthdate: _____ Social Security # _____

Birth Place: _____ Sex: _____

Driver's License # _____ Criminal History _____

Marital Status: _____ (If Married) Spouse's Name: _____

Number of Dependents: _____ Highest Level of Education: _____

INSURANCE DATA

Your Health Insurance: _____

Address: _____

Telephone Number: (_____) _____

Policy Number: _____

EMPLOYMENT OVERVIEW

Employer: (Where injury occurred) _____

Address: _____

Wage Per Week: \$: _____ Job Title: _____

Number of hours worked per week: _____

Average number of overtime hours per week PRIOR to injury _____

Date of Hire: _____ Supervisor: _____

Briefly describe the nature of your work, indicating the type or physical activity it involves (such as how much bending, lifting, stooping, etc.) _____

EMPLOYER'S INSURANCE DATA

Work Comp Insurer: _____

Address: _____

Adjuster's Name: _____

Telephone Number: (_____) _____ Claim No: _____

Fax: (_____) _____

INJURY OVERVIEW

Date Injured: _____ Where injury occurred: _____

How did your injury happen? _____

Describe what injuries you received: _____

List days working, making less money as a result of your injury: _____

INJURY INVESTIGATION

Was the accident investigated by anyone? Yes No
If yes, who investigated and what company were they from? _____

Did you sign any statement(s) regarding the accident? Yes No
If yes, who took the statement(s)? _____

Do you have a copy that you can provide our office with? Yes No

List the information requested for anyone who witnessed your injury.

Name	Address	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS INJURIES

List the information requested for any other injuries/accidents that happened before your work comp injury. (Use the back of this sheet for additional space.)

Date	Injury Description	Off Work from: To:
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT BENEFITS

Are you currently being denied work comp benefits: Yes No
If yes, please check all that apply:

- Medical/Chiropractic Care
- Permanent Injury
- Retraining
- Mileage Reimbursement
- Wage Loss
- Rehabilitation

Have you received any other benefits since your work comp injury? (Check all that apply)

- Unemployment
- Welfare
- General Assistance
- AFDC
- SSDI
- VA Benefits
- Long-term Disability (Paid by: _____)
- Short-term Disability (Paid by: _____)
- Other _____

AS A RESULT OF YOUR INJURY...

List all doctors you have seen **as a result** of this accident. (Use the back of this page for additional space.)

Doctor: _____

Clinic Name: _____

Address: _____

Phone: (_____) _____ Date 1st Treated: _____ Round Trip Miles _____

Doctor: _____

Clinic Name: _____

Address: _____

Phone: (_____) _____ Date 1st Treated: _____ Round Trip Miles _____

Doctor: _____

Clinic Name: _____

Address: _____

Phone: (_____) _____ Date 1st Treated: _____ Round Trip Miles _____

Doctor: _____

Clinic Name: _____

Address: _____

Phone: (_____) _____ Date 1st Treated: _____ Round Trip Miles _____

Doctor: _____

Clinic Name: _____

Address: _____

Phone: (_____) _____ Date 1st Treated: _____ Round Trip Miles _____

MEDICAL HISTORY BEFORE ACCIDENT

List all doctors or chiropractors you have received treatment from **before** this accident.
(Use the back of this page for additional space.)

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

Doctor: _____ City: _____

What were you treated for? _____

_____ Date of last treatment _____

PREVIOUS EMPLOYMENT HISTORY

List your past employers for the last 10 years, starting with the **most recent**.

Employer: _____

Address: _____

Occupation: _____ Wage Per Week: \$ _____

Reason for Leaving: _____

Start Date: _____ Stop Date: _____

Employer: _____

Address: _____

Occupation: _____ Wage Per Week: \$ _____

Reason for Leaving: _____

Start Date: _____ Stop Date: _____

Employer: _____

Address: _____

Occupation: _____ Wage Per Week: \$ _____

Reason for Leaving: _____

Start Date: _____ Stop Date: _____

Employer: _____

Address: _____

Occupation: _____ Wage Per Week: \$ _____

Reason for Leaving: _____

Start Date: _____ Stop Date: _____

Employer: _____

Address: _____

Occupation: _____ Wage Per Week: \$ _____

Reason for Leaving: _____

Start Date: _____ Stop Date: _____