Date: # POTENTIAL CLIENT QUESTIONNAIRE Referral Source:

PERSONAL INFORMATION

Name (First, MI, Last): ______________________________ Telephone : ____________________ (Home)

Street Address/ P.O. Box: ______________________________ ____________________ (Work)

City, State, ZIP: ______________________________ ____________________ (Other)

Soc. Sec. #: ______-_____-_______ Date of Birth ____/____/____ Do you owe child support in any jurisdiction? ___YES ___ NO

EDUCATION

High School -- Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 Did you graduate? ___ YES ___ NO

College: 1 2 3 4 5+ Did you graduate? ___YES ___ NO If Yes, Degree: ______________________________

Do you have any specialized technical skills or work training? ___ YES ___ NO If Yes, Explain: ______________________________

EMPLOYER/CARRIER INFORMATION

Employer Name: ______________________________

Mailing Address: ______________________________

City, State, ZIP: ______________________________

Supervisor: ______________________________

Telephone: ______________________________

Your job title: ______________________________

Length of time with the company: ____________________

Still employed by company? ___ YES ___ NO

Workers' Comp Carrier: ______________________________

Mailing Address: ______________________________

City, State, ZIP: ______________________________

Adjuster / Claims Rep.: ______________________________

Telephone: ______________________________

Your wages at the time of injury:

(a) $_____.___ per hour, _____ hours per week

(b) Gross salary of $___,______.___ per week

If NO, explain: ______________________________

ACCIDENT INFORMATION

Place of accident (Include city and county): ______________________________ Date of accident: ____________________

Brief description of accident: ______________________________

Body part(s) injured: ______________________________ Date employer notified of accident: ____________

Medical Providers in order or treatment:

____

____

____

____

____

How was employer notified? ____________

Third party involved? ___ YES ___ NO If YES, explain:

____

____

Any prior WC accidents or other accidents? ___ YES ___ NO If YES, explain:

____

Was a written or recorded statement taken by anyone? If so, by who and when? ______________________________

WORK STATUS

Did your doctor release you to work? ___ YES ___ NO If yes, date returned to work: ______________________________

Returned to work for ____ previous employer _____ new employer. If new:

Employer's Name: ______________________________ Salary at new job: ____________________

Mailing address: ______________________________

City, State, ZIP: ______________________________ Telephone: ____________________