
LAW FIRM OF

# LAUB & LAUB

A Professional Corporation

PERSONAL INJURY
WORKERS COMPENSATION
CRIMINAL DEFENSE
BANKRUPTCY

## WORKER'S COMPENSATION CLIENT QUESTIONAIRE

### I. PERSONAL INFORMATION

Name _____ Today's Date _____

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Spouse's Name _____ Work Phone # _____

Closest Relative _____ Relationship _____ Phone # _____

Referred By _____

### II. INJURYINFORMATION

**DATE OF INJURY** _____

Did you report the injury to your employer? Yes____ No____

When did you report the injury to your employer? Date _____

To whom did you report the injury? Name_____ _____Title _____

Did you report injury in writing? Yes_____ No _____

Do you have a copy? Yes _____ No _____

How did the injury happen?

_____

_____

Were there any witnesses to the injury? Yes _____ No _____

Name _____Address _____Phone # _____
Name _____Address _____Phone # _____

## III . EMPLOYMENT INFORMATION

Name of your employer on date of injury _____

Employer's address _____ Phone # _____

Your job title and duties on the date of injury _____

_____

Date you were hired: _____

### 1. YOUR WAGES ON THE DATE OF YOUR INJURY

Your rate of pay $_____ Per Hour/No. Hours/ Per Week _____

Did you have a second job at the time of injury? Yes _____ No _____

What was your rate of pay at your second job? $ _____

### 2. YOUR LOST TIME FROM WORK SINCE THE DATE OF YOUR INJURY

Have you missed time from work because of your injury? Yes_____ No _____

How much time have you missed? _____

Have you missed time from second job? Yes _____No _____How Much Time? _____

### 3. YOUR CURRENT WORK STATUS

Are you working now? Yes _____ No _____

Are you working for the same employer? Yes _____ No _____

If not, the name of your current employer : _____

When did you return to work? Date

_____

Is the job you are now working a light duty job? Yes _____ No _____

What is the rate of pay? Amount $_____ Per _____

Please describe your current job duties _____

_____

## IV. MEDICAL INFORMATION

What part(s) of your body was injured? _____

Who is your treating doctor? _____ Phone #_____

Please list all hospitals and medical providers where you have received treatment or testing for your injuries:

NAME ADDRESS PHONE DATE 1ST SEEN

_____

_____

_____

## V. WORKER'S COMPENSATION CLAIM INFORMATION

Has your claim for worker's compensation benefits been:

Accepted _____ Denied _____ Don't know_____

What is your claim number? _____ Name of Examiner_____

Name of MCO _____

Is there currently a hearing scheduled before a hearing officer or appeals officer? Yes___ No___

Date and time of hearing : _____Reason for hearing: _____

## VI. PRIOR INJURIES

Before your injury at work, did you ever injured the same part(s) of your body? Yes____ No___

Date of prior injury _____ State where it occurred _____

Please list all hospitals and medical providers where you received treatment or testing for your prior injury:

_____

_____

_____

Did the prior injury also occur at work? Yes _____ No_____

Name of your employers at the time of the prior injury: _____

The prior claim # _____ Date Filed _____ State _____

Is the prior claim still open? Yes _____ No _____

Did you receive a settlement or a permanent partial disability award for your prior injury?
Yes_____ No _____ If so Date of award _____

## VII. INSURANCE INFORMATION

Health insurance? Yes_____ No_____ Name of insurance Company:_____

Address: _____ Name of insurance agent_____

## VIII. YOUR PROBLEMS AND CONCERNS

Please describe the problems or concerns you have about your claim for which you would like our help:

_____

_____