WORKER'S COMPENSATION
C L I E N T Q U E S T I O N N A I R E

PERSONAL BACKGROUND

Name _____

Address _____

Telephone Number _(_____)_____

Date of Birth ____/____/____ Social Security Number _____ - _____ - _____

Martial Status: _____ single _____ married _____ divorced _____ widowed

If married, give the following information for your spouse:
Name _____ Date of Birth ____/____/____
Occupation _____
Employer _____

Children
Name _____ Date of Birth ____/____/____
Name _____ Date of Birth ____/____/____
Name _____ Date of Birth ____/____/____
Name _____ Date of Birth ____/____/____

EDUCATION

Grammar School
Name _____
Years Attended _____

High School
Name _____
Years Attended _____
Graduate Yes _____ No _____

College
Name _____
Years Attended _____
Graduate Yes _____ No _____
Degree or major course of study _____

Trade School

Name _____

Years Attended _____

Graduate Yes _____ No _____

Degree or major course of study _____

Vocational School

Name _____

Years Attended _____

Graduate Yes _____ No _____

Degree or major course of study _____

Please provide any military service information, if applicable

EMPLOYMENT HISTORY

List your four most recent jobs, beginning with your present job:

1. Employer Name

Employer Address _____

Occupation

Start Date ____/____/____ End Date ____/____/____

Reason for Leaving

Salary at Time of Leaving

Brief Description of Job Duties

2. Employer Name

Employer Address _____

Occupation

Start Date ____/____/____ End Date ____/____/____

Reason for Leaving

Salary at Time of Leaving

Brief Description of Job Duties

3. Employer Name
Employer Address _____
Occupation
Start Date ____/____/____ End Date ____/____/____
Reason for Leaving
Salary at Time of Leaving
Brief Description of Job Duties

4. Employer Name
Employer Address _____
Occupation
Start Date ____/____/____ End Date ____/____/____
Reason for Leaving
Salary at Time of Leaving
Brief Description of Job Duties

If you do not currently work, the date of your last employment ____/____/____

Did you ever return to work after the disability _____
If yes, was it the same job that you held when you were disabled _____

If no, please provide the following information if not provided above:

Employer Name
Employer Address _____
Occupation
Start Date ____/____/____ End Date ____/____/____
Reason for Leaving
Salary at Time of Leaving
Brief Description of Job Duties

Yearly salary during the last year you worked _____
Yearly salary for this year
List amounts and types of any other sources of income (ie. pension, insurance, worker's comp, welfare, etc.)
_____

INJURY

Brief description of injury

-

Brief description of how you were injured

Date of injury _____/_____/_____Disability is expected to
last less than 12 months _____
last more then 12 months _____

Check the abilities which are adversely affected by your impairment:

sight_____hearing_____
speech_____behavior _____
memory _____demeanor_____
thought process _____manual dexterity _____
concentration _____

For each of the following abilities adversely affected by the impairment, please list the amount of time that you are able to complete the following without pain (ie. you can normally only sit for 15 minutes without experiencing any pain):

sitting _____standing_____
walking _____lying down _____
sleeping _____lifting _____
bending _____stooping _____
squatting_____reaching _____
carrying _____climbing stairs _____

What amount of weight could you lift before the impairment
What amount of weight can you lift now _____

What daily activities can you not perform because of your injury which you could perform prior to the impairment (ie. laundry, cooking, cleaning, etc.)

What recreational activities can you not perform because of your disability which you could perform prior to the impairment (ie. golf, exercise, swimming, etc.)

Do you experience any of the following?

headaches _____
how often _____ how severe _____
dizziness _____
how often _____ how severe _____

fatigue _____

how often _____ how severe _____

amount of time you need to rest in order to resume your activities _____

vomiting _____

frequency _____

pain _____

where _____ duration _____

severity _____ frequency _____

pain _____

where _____ duration _____

severity _____ frequency _____

MEDICAL HISTORY

List all the physicians who treated your claimed disability:

1. Physician _____
   Address
   Telephone Number (_____) _____ Specialty
   Dates of Visits
   Condition Treated _____
   Treatment Prescribed _____
   _____

2. Physician _____
   Address
   Telephone Number (_____) _____ Specialty
   Dates of Visits
   Condition Treated _____
   Treatment Prescribed _____
   _____

3. Physician _____
   Address
   Telephone Number (_____) _____ Specialty
   Dates of Visits
   Condition Treated _____
   Treatment Prescribed _____
   _____

4. Physician _____
Address
Telephone Number (_____) _____ Specialty
Dates of Visits
Condition Treated _____
Treatment Prescribed _____
_____

5. Physician _____
Address
Telephone Number (_____) _____ Specialty
Dates of Visits
Condition Treated _____
Treatment Prescribed _____
_____

List all hospitals visited due to your claimed disability:

1. Hospital _____
Address
Telephone Number (_____)
Date Admitted _____/_____/_____ Date Discharged _____/_____/_____
Condition Treated _____
Surgeries Performed _____
Surgeon _____
Treatment Prescribed _____
_____

2. Hospital _____
Address
Telephone Number (_____)
Date Admitted _____/_____/_____ Date Discharged _____/_____/_____
Condition Treated _____
Surgeries Performed _____
Surgeon _____
Treatment Prescribed _____
_____

List all medications taken for your injury:

1. Medication name
Dosage
Dates during which the medication was taken _____
Frequency medication was taken _____
Condition medication prescribed for _____
Prescribing physician _____

2. Medication name
Dosage
Dates during which the medication was taken _____
Frequency medication was taken _____
Condition medication prescribed for _____
Prescribing physician _____

3. Medication name
Dosage
Dates during which the medication was taken _____
Frequency medication was taken _____
Condition medication prescribed for _____
Prescribing physician _____

SOCIAL SECURITY OR INSURANCE INFORMATION

Have you filed a claim? _____
If yes, which claim was filed:
_____ Supplemental Security Insurance _____ Social Security Disability
_____ Insurance

If yes, list the date of filing _____/_____/_____

If yes, list the date the claim was denied _____/_____/_____

Have you been examined by a Social Security Insurance Co. physician? _____
Physician _____
Address
Telephone Number (_____)_____ Specialty
Dates of Visits
Condition Treated _____
Treatment Prescribed _____
_____