Law Office of Michael J. Hurley

WORKERS' COMPENSATION INTAKE SHEET

Date: ______________________ Case Accepted: ______________________

Referred By: ______________________

CLIENT INFORMATION:

Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Telephone: ______________________ (Home) ______________________ (Work)

Alternative Telephone: (friend/relative/neighbor) ______________________

Social Security Number: ______________________ Date of Birth: ______________________

Education (Years of School): __________ Height: __________ Weight: __________

Specialized Training or Degrees: ______________________

Sex: ______________________ Race: ______________________

FAMILY INFORMATION:

Married? __________ Spouse Name: ______________________

Spouse's Employer: ______________________

Address: ______________________

____

Telephone: ______________________

Dependent Children:

Name: ______________________ Age: __________

Name: ______________________ Age: __________

Name: ______________________ Age: __________

Name: ______________________ Age: __________

______________________ __________

ACCIDENT INFORMATION

Date of Accident: ____________________

Location of Accident: ____________________

Nature of Injuried: ____________________

County Where Injured: ____________________

DESCRIBE HOW THE ACCIDENT OCCURRED:

____

____

____

____

EMPLOYER INFORMATION:

Name of Employer: ____________________

Address: ____________________

City, State, Zip: ____________________

Other Employment: ____________________

COMPENSATION:

Wage Rate (Hourly or Weekly Pay Before Deductions): ____________________

Overtime (Average Number of Hours Worked Weekly): ____________________

Compensation Rate (To Be Completed by Attorney): ____________________

Length of Employment with Employer: ____________________

Wages from Other Employment: ____________________

Time Away from Work Due to Accident: ____________________

Amount of Workers' Compensation Already Paid: ____________________

DESCRIBE HOW THE ACCIDENT OCURRED

Job Title at Time of Accident:

Regular Job Duties at Time of Accident:

To Whom Was Accident Reported?

When Was Accident Reported?

INSURANCE INFORMATION:

Employer's Workers' Compensation Carrier (If Known):

Name of Carrier:

Carrier Address:

City, State, Zip:

Adjuster Name:

Adjuster Telephone:

MEDICAL INFORMATION:

DOCTORS:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ______________________________

HOSPITALS:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: __________ ______________________________

X-Rays Taken: __________ Surgery? __________ Diagnostic Tests? __________

Date Admitted: ____________________ Date Discharged? __________

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: __________ ______________________________

X-Rays Taken: __________ Surgery? __________ Diagnostic Tests? __________

Date Admitted: ____________________ Date Discharged? __________

EMS of Ambulance Service: ______________________________

WITNESSES TO ACCIDENT:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ____________ (Home) ____________ (Work)

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ____________ (Home) ____________ (Work)

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ____________ (Home) ____________ (Work)

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Telephone: ____________ (Home) ____________ (Work)

PRIOR WORKERS' COMPENSATION CLAIMS:

Ever Been Hurt in an Accident Before: ____________

If so, when, what, where and how? ______________________________

____

____

____

What Doctors Were Consulted? ______________________________

____

____

____

Previous Attorney Representation? ______________________________

Name, Address and Telephone Number of Attorney: ______________________________

____

____

ADDITIONAL COMMENTS:

____

____

____

____

____

____

CRIMINAL RECORD:

No ____________________ Yes ________________

If yes, explain: ____

____

____

____

LAWSUITS, WRECKS, SETTLEMENTS:

No ____________________ Yes ________________

If yes, explain: ____

____

____

____

PSYCHIATRIC/DRUG/ALCOHOL TREATMENT OR REHABILITATION:

No ____________________ Yes ________________

If yes, explain: ____

____

SOCIAL SECURITY APPLICATIONS FOR DISABILITY:

No ____________________ Yes ________________

If yes, explain: ____

CLIENT EXPECTATIONS:

What problems are you having with this claim? ________________________________

Why have you decided to get an attorney involved?

What do you hope to achieve from retaining counsel?

ATTORNEY COMMENTS:

Submission of this form does not create an attorney-client relationship. Complete the information and we will respond as soon as possible.

916 . 865 . 4442
Info@HurleyLawRoseville.com
313 Judah Street, Suite 3
Roseville, Ca 95678

www.HurleyLawRoseville.com