## ***NEW CLIENT INFORMATION***

FULL NAME: (Mr.) or (Mrs.) or (Ms.)
_____

STREET ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (___)_____ WORK PHONE: (___)_____

CELL PHONE: (___)_____ E-MAIL: _____

SSN: _____ AGE ____ DOB _____ MARITAL STATUS _____

PRIMARY LANGUAGE: _____
SECONDARY_____

COUNTRY: _____ DIALECT: _____

*Other contact:* NAME _____ PHONE (___)_____

Relationship to you: _____

**HOW DID YOU FIND OUR FIRM?**

ONLINE _____ SEARCH USED: _____

ATTORNEY_____ NAME OF ATTORNEY: _____

OTHER: _____

## EMPLOYMENT INFORMATION AT TIME OF INJURY

EMPLOYER NAME
_____

STREET ADDRESS
_____

CITY, STATE AND ZIP _____ PHONE:
_____

DATE OF INJURY: _____ COUNTRY OF INJURY:
_____

Position: _____ Length of Time Employed:
_____

Earnings: $ _____ weekly? yearly? Hourly wage $ _____ Hours per week
_____

*********PLEASE PROVIDE A COPY OF MOST RECENT PAY STUB**********

Briefly describe the physical demands of your job (example: lifting, bending, prolonged standing, kneeling, squatting,
etc.)_____
_____
_____

## OTHER EMPLOYMENT AT TIME OF INJURY

At the time of your injury, were you working ANOTHER full-time or part-time job? If yes, complete the following:

EMPLOYER NAME
_____
EMPLOYER ADDRESS
_____
_____
_____

EMPLOYER PHONE _____ Position
_____

Length of Time Employed: _____ Hourly Wage $ _____ Hours per week
_____

**********PLEASE PROVIDE A COPY OF MOST RECENT PAY

STUB**********

## INSURER INFORMATION AT TIME OF INJURY

Workers' Compensation Insurer:
_____

Adjuster Name:_____ Phone:
_____

Are you receiving workers' compensation benefits? If yes, how much? $
_____

Are you receiving medical bills from your doctor (s) demanding payment?
_____

## ACCIDENT INFORMATION

HOW WERE YOU HURT? (Please describe in detail)
_____
_____
_____
_____

WHO DID YOU NOTIFY OF YOUR INJURY?

| *Name* | *Title/Position* | *Date/Time Notified* |
|---|---|---|

_____
_____
_____
_____
_____

WERE THERE ANY WITNESSES TO YOUR ACCIDENT? (If so, please list below)

| Name | Address | Phone |
|---|---|---|

_____
_____
_____

Are you currently out of work because of your injury?
_____

If so, what was the first date you missed work?
_____

After your injury, did you stop working?

_____

How much time did you miss from work?

_____

Have you returned to work?

_____

If so, what was the date you returned to work?

_____

## MEDICAL TREATMENT RECEIVED

Please list *all* doctors, hospitals, physical therapists, etc. you have seen since your work-related injury.

NAME ADDRESS PHONE

_____
_____
_____
_____
_____
_____

Did any doctor tell you to stay out of work? _____ If so, who?

_____

PART(S) OF BODY INJURED

_____

Have you ever injured these body part(s) before? (If so, please describe when, how, and if it was work-related.)

_____
_____
_____

Who provided medical treatment for this PREVIOUS injury to these body part(s)?

_____
_____
_____

If this PREVIOUS injury was work-related, please list your previous employer's name, address and telephone:

_____
_____

_____

Was a workers' compensation claim filed?
_____
_____
_____

If so, what was the outcome?
_____

## PRIOR WORK HISTORY

| Employer Name/ Address | Position | Dates Employed | Salary | Reason Left |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Have you ever filed a workers' compensation claim before?
_____
If so, please list below:

| Employer Name/ Address | Type of Injury | Date | Outcome |
|---|---|---|---|
| 1. | | | |
| 2. | | | |

## PRIOR MEDICAL HISTORY

Family Doctor (Please list Name, Address, Phone)
_____
_____
_____

When was the last time you saw *any* doctor?

_____

For what reason?
_____

Have you ever been hospitalized? _____ If so, please list below:

Dates Reason Doctor

_____
_____

_____
_____

**MISCELLANEOUS**

1. Do you have any outstanding Child Support Liens?
_____

2. Do you have any other personal injury actions pending or a result of this accident?

3. Ever been charged with a felony? _____