

*** For Office Use Only ***

Our File Number _____ County of Accident _____
Date of Injury _____ Type of Injury _____
Current Work Status _____ Date of Last Wage Check _____

WORKERS' COMPENSATION QUESTIONNAIRE

PERSONAL INFORMATION

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Telephone (Home) _____ (Cell) _____

Other Phone or Pager _____ Fax: _____

Email _____ Work or Other Phone _____

Social Security No. _____ Date of Birth _____

Marital Status: **S M D SEP W** Name of Spouse _____

EMERGENCY CONTACT: Relative or Friend who will always know how to reach you.

Name: _____

Address: _____

Phone Number: _____

How far did you go in school? _____

How did you hear about Attorney David K. May? _____

NOTE: PLEASE UPDATE OUR OFFICE WHENEVER YOU HAVE A CHANGE IN YOUR MAILING ADDRESS OR TELEPHONE NUMBER OR IF YOUR PHONE IS DISCONNECTED.

EMPLOYER INFORMATION:

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: _____ Fax No.: _____

Date Hired: _____ Job Title at time of injury: _____

Describe your job duties: _____

Name of your immediate supervisor: _____

Job Title of immediate supervisor: _____

Are you still employed with this employer? YES _____ NO _____

If no, date terminated or resigned: _____

Reason for termination or resignation: _____

Are you a union member? YES _____ NO _____

What is the nature of your employer's business? _____

Is this your only employer? YES _____ NO _____

If no, please list the name and address of any other employer _____

WAGE INFORMATION:

Hourly \$ _____ Rate of pay (before tax deductions)

Number of hours worked per day _____ Number of hours worked per week _____

Your wages are paid : Weekly Monthly Bi-Weekly Other

If you receive tips, bonuses, or commissions, how much did they average per week? _____

ACCIDENT INFORMATION:

Date of Accident: _____ Time: _____

County of Accident: _____

Location of accident (Where were you?) _____

Is your employer denying you were hurt on the job? YES _____ NO _____

Please describe in detail how the accident occurred (if you need more space, you may continue on the back):

Were you going to or from your job at the time of the accident, or on a work related errand? If yes, please describe:

Was a party other than your employer at fault in the accident? If yes then please describe: _____

ATTORNEY INFORMATION:

Have you been represented by an attorney for this accident? YES _____ NO _____

If yes, please list his/her name, phone number and address: _____

Have you terminated the attorney? YES _____ NO _____

Please state why the attorney was terminated or has resigned _____

If the attorney has been terminated or has resigned, has the attorney filed a lien?

YES _____ NO _____

YOUR INJURIES:

Please list **all** of the injuries you sustained in this accident: _____

WITNESSES:

1. Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone (Home): _____ (Work): _____

2. Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone (Home): _____ (Work): _____

3. Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone (Home): _____ (Work): _____

4. Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone (Home): _____ (Work): _____

NOTICE:

Did you give notice of the accident to your employer? YES _____ NO _____

Name and Job Title of person to whom you gave notice: _____

Give details of how you gave notice, including date, time, place, and witnesses:

WORKERS' COMPENSATION INSURANCE INFORMATION:

Workers' Compensation Insurance or Claims Management Company:

Address: _____

Adjuster Name: _____ Phone No.: _____ EXT: _____

Fax No.: _____ Adjuster email address: _____

Claim Number: _____

Have you spoken to the insurance adjuster? YES NO

Have You Been Denied Any Weekly Checks or Medical Treatment? YES _____ NO _____

If yes, please list all income benefits or medical treatment being denied by workers' compensation and why the insurer is denying benefits

WORKERS' COMPENSATION BENEFITS:

Have you received any weekly benefit checks for your injury? YES NO

If yes, what was the weekly amount? _____

Have you been disabled from work or been given work restrictions? YES NO

If you have work restrictions in place, please list your restrictions: _____

When did you first lose time from your job due to your injury? _____

Are you still off the job due to your injuries? YES NO

If you returned to work for the same employer, when did you go back to work? _____

Did you have any decrease in your earnings after returning to work? YES NO

Have you at anytime lost income due to your injuries after the accident? YES ____ NO ____

Have you used any "sick days" offered by your company? YES _____ NO _____

Have you been assigned an impairment rating? YES _____ NO _____

If yes, please list the impairment rating you have been assigned and who assigned it.

If you are working or have worked for another employer since your accident, list the name, address, and phone number of the employer and the dates you worked: _____

MEDICAL TREATMENT:

List every provider where you have had medical treatment for injuries suffered in the accident

PROVIDER	FIRST TREATMENT	LAST TREATMENT	NOTES
1.			
2.			
3.			
4.			

5.			
6.			
7.			

Please Note: You should request your work status **in writing** after each visit with your primary doctor, and provide a copy to my office. All referrals from your doctor must be in writing for them to be approved by the insurance company. Please keep our office updated regarding your medical treatment and work status and provide our office with a copy of any records or bills you receive. In addition, should any offer of employment be made to you, please let me know immediately. Under no circumstances should you return to work without first discussing the matter with your attorney.

OTHER INSURANCE INFORMATION:

Health Insurance Company (including Medicaid/Medicare): _____

Address: _____

Phone No.: _____ Fax No.: _____

Policy Number: _____ Insured: _____

Has your health insurer paid any benefits from your work accident? YES _____ NO _____

Has your health insurer denied any benefits from your work accident? YES _____ NO _____

Do you have any additional insurance or other disability benefits compensating you or potentially compensating you for wage loss or providing other benefits? YES _____ NO _____

If yes, please describe the coverage or benefits and list the name and address of the insurer/benefit provider:

Do you have a private disability insurance plan with your company? YES _____ NO _____

Has your private disability insurance plan paid any benefits from your work accident?
 YES _____ NO _____

Has your private disability insurance plan denied any benefits from your work accident?
YES _____ NO _____

Do you have any additional insurance or other disability benefits compensating you or potentially compensating you for wage loss or providing other benefits? YES _____ NO _____

Are you a veteran of the United States Armed Forces? YES _____ NO _____
If yes, have you treated at the VA for injuries sustained from your work accident?
YES _____ NO _____

Do you reside in Fulton or Dekalb County? YES _____ NO _____

If yes, have you treated in the Grady Health System for any reason? YES _____ NO _____

PRIOR INJURIES:

Prior to this accident, have you ever been injured in a work-related accident or filed a workers' compensation claim? YES NO

If yes, please list the type of accident and approximate date of injury:

YEAR	EMPLOYER	PART (S) OF BODY INJURED

Prior to this accident, have you ever been injured in any non-work related accident?

YES _____ NO _____

YEAR	LOCATION OF ACCIDENT	PART (S) OF BODY INJURED

Prior to this accident, have you ever filed a claim for personal injury, social security, disability insurance or unemployment benefits? YES_____ NO_____

If yes, please list the type of claim filed, the company or state agency the claim was filed with, why the claim was filed, and the disposition of the claim:

Please list any medical conditions or diseases you have which are unrelated to your work accident:

Do any of the above referenced medical conditions or diseases interfere with your ability to work? YES_____ NO_____

List any past lawsuits you have been involved in, giving the full details as to each case:

Were you represented by an attorney for any of the above-referenced accidents, claims or lawsuits? YES_____ NO_____

If yes, please list the attorney's name, address, phone number and the accident, claim or lawsuit for which you were represented:

Have you ever had surgery for this accident or any other accident? YES_____ NO_____

YEAR	TYPE OF SURGERY

THE FOLLOWING INFORMATION WILL BE TREATED IN THE STRICTEST CONFIDENCE:

Have you ever been diagnosed either by yourself or a health care provider as suffering from alcoholism or drug addiction? YES _____ NO _____

If yes, please describe _____

Have ever been treated for alcoholism or drug addiction or sought assistance at a detox center? YES _____ NO _____

Please list when and where you have been treated for alcoholism or drug addiction

Have you ever been arrested or convicted of a violation of any criminal statute? (except minor traffic offenses). If yes, please list the date of arrest, the jurisdiction where arrested, disposition of the case, whether you were convicted of a misdemeanor or felony, and please discuss below with your attorney.

I VERIFY THAT THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Date

Client Signature