WORKERS' COMPENSATION
CLIENT INTERVIEW SHEET

FILE NO. ______________________ D/I _________________________ SOL ________________________
OPENED_______________________ COMMISSION FILE NO. _________________________________
SOURCE ____ LAWYER _____/_____ LA ______

CLIENT INFORMATION:

____
NAME (First, Middle, Last) NAME CALLED

____
CLIENT MAILING ADDRESS STREET ADDRESS (If Different)

____
CITY STATE ZIP

HOME PHONE_________________________ WORK PHONE ____________________________

OTHER PHONE ____________________ NAME & RELATIONSHIP ______________________

CLIENT AGE _______ CLIENT D.O.B. ________________ CLIENT SS NO. ______________

CLIENT RACE ______ MARITAL: Married/Single/Divorced/Widowed/Separated ___________
Date

CLIENT'S SPOUSE ___________________________ CHILDREN _________________________

SPOUSE GROUP INS. ____

OTHER HEALTH INSURANCE COV. ____

CRIMINAL RECORD ____

REGISTERED TO VOTE? ____

EMPLOYER INFORMATION:

____
EMPLOYER PHONE NUMBER

____
EMPLOYER'S ADDRESS (Street, City, State, Zip)

DATE EMPLOYED _______________________ JOB TITLE _____________________________

RATE OF PAY ________________ AVG. HRS./DAY _______________SHIFT ____________

SUPERVISOR ____

STD/LTD/SICK PAY ____
Company

HEALTH INSURANCE COMPANY ____________________________________

TEMPORARY TOTAL PAID Y/N DATES _______________________________

AMOUNT $_____________________ CORRECT AMOUNT $_______________

PART-TIME EMPLOYMENT Y/N EMPLOYER ___________________________

____
ADDRESS OF PART-TIME EMPLOYER

RATE OF PAY ________________ LOST WAGES Y/N DATES MISSED _________

CARRIER INFORMATION:

____
WORKERS' COMP INSURANCE CARRIER

____
CARRIER'S ADDRESS (Street or P.O.>Box, City, State, Zip)

____
ADJUSTER PHONE NUMBER

____
INSURED CLAIM NUMBER POLICY NUMBER

THIRD PARTY DEFENDANT:

____
ADVERSE PARTY'S NAME (First, Middle, Last)

____
AP'S ADDRESS (Street or P.O. Box, City, State, Zip)

THIRD PARTY INSURANCE INFORMATION:

____
INSURANCE COMPANY

____
INSURANCE COMPANY ADDRESS

____
ADJUSTER PHONE NUMBER

____
INSURED

ACCIDENT INFORMATION:

DATE OF INJURY ________________________ TIME ____________ COUNTY ___________

PART(S) OF BODY INJURED ____

DESCRIBE HOW ACCIDENT OCCUURED ____

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ACCIDENT REPORTED Y/N TO ____

TITLE/POSITION ______________________________ DATE REPORTED ________________

WITNESSES ____

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MEDICAL TREATMENT:

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CLAIM HISTORY:

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PRIOR MEDICAL / CLAIM HISTORY: