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

ACCIDENT REPORTED Y/N TO _____

TITLE/POSITION _____ DATE REPORTED _____

WITNESSES _____
_____

MEDICAL TREATMENT:

CLAIM HISTORY:

PRIOR MEDICAL / CLAIM HISTORY:

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