

WORKERS' COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Injury: _____
Address: _____ Job Title: _____
City: _____ St: _____ Zip: _____ WAGES (Gross hourly/week) _____
Social Security No: _____ | _____ | _____ Date of Birth _____ Date Hired: _____
Home Phone: _____ Business Phone: _____ Date(s) Last Worked: _____
Cell Phone: _____ Email: _____ Group Medical Insurance: _____

Parts of the Body Injured: _____

How did the injury happen? (describe): _____

Where did the injury happen? _____

What are your job duties? _____

Temporary Disability Paid By Workers' Compensation? YES NO

Medi-Cal Benefits Received? YES NO

State Unemployment/Disability Received? YES NO

EMPLOYER: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____

Prior Job Injuries? YES NO Any Other Personal Injuries? YES NO Dates: _____

Prior Workers' Compensation Case(s) Filed? YES NO

Year: _____ City: _____ Injury _____

Year: _____ City: _____ Injury _____

Treating Doctor(s): _____

Address: _____ Phone: _____

Was the Doctor Provided by Your Employer/Insurance? Y N Date of Last Treatment: _____

Released to Work? Y N Date: _____ Modified? YES NO _____

EMPLOYER'S INSURANCE COMPANY: _____

Address: _____ Phone: _____

Person to Contact at Employment about Compensation Insurance: _____

Name of prior attorney if any: _____

Who Referred You to This Office? _____