**WORKERS’ COMPENSATION INTAKE FORM**

**Date:**

**NAME:**

**ADDRESS:**

**EMAIL:**

**HOME PHONE:**

**DATE OF BIRTH**

**Referred By: Attorney Requested:**

**REASONS FOR SEEKING COUNSEL:**

**EMPLOYER**:

**EMPLOYER’S CITY/STATE**:

**DATE OF HIRE**: **STILL EMPLOYED?**:

**DATE OF INJURY**: **JOB TITLE**:

**EARNINGS**:

**HAVE THEY RETURNED TO WORK**:

**BODY PART AFFECTED**:

**HOW INJURY OCCURRED**:

**TREATING DOCTOR/FACILITY**:

**WHAT TYPE OF DOCTOR**:

**TYPE OF TREATMENT RECEIVED**

**CURRENT TREATMENT:**

**EVALUATIONS**:

**While unrepresented, have you seen a QME?** **Have you been offered a panel of three doctors?**

**If yes, When & what Doctor:**

**CLAIM FORM FILED**:

**CARRIER NAME**:

**PRIOR INJURIES?**: **PRIOR WCAB CLAIMS?**:

**FURTHER COMMENTS**:

**Do you already have an Attorney for this claim?**