WORKER'S COMPENSATION QUESTIONNAIRE

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The following information will be needed by **The Reynolds Law Firm, LLC** in order to properly advise you and handle your case. Please print and fill out every applicable question. If a question is not applicable, please write N/A in the space. DO NOT LEAVE BLANKS. This information will help us help you. **THIS INFORMATION WILL BE KEPT CONFIDENTIAL**.

Date: _____

HOW DID YOU HEAR ABOUT THIS OFFICE: _____

I. Your Background Information:

Full legal name: _____

Address: _____

Home phone: _____ Email address: _____

Birthdate: _____ Birth place: _____

Soc. Sec. No.: _____ Driver's Lic. No.: _____

Cell phone: _____

II. Your Current Employment Information:

Employer: _____

Work Address: _____

Work phone: _____ Work Hours: _____

Rate of Pay: _____ (Provide gross annual rate of pay)

Have you lost any time for work, if so please state the dates and number of yours lost from work due to your injuries and medical appointments:

_____

_____

III. Your Employment Information at the Time of the Work Related Accident:

Employer: _____

Work Address: _____

Work phone: _____ Work Hours: _____

Rate of Pay: _____ (Provide gross annual rate of pay)

Have you lost any time for work, if so please state the dates and number of yours lost from work due to your injuries and medical appointments:

_____

_____

IV. Work Related Accident Information:

Date: _____ Day of week: _____

Time: _____

Location: _____

Describe how the accident happened:

_____

_____

_____

_____

_____

_____

Your Average Weekly Wage at Time of Accident: _____

After the injury did you receive temporary total disability (TTD) checks, and if so please state:

The Amount Paid for TTD: _____

Number of Weeks TTD Received: _____

V. Witnesses:

Did the police, law enforcement or governmental agency (OSHA) come to the accident scene or conduct an investigation? If so, please provide details: _____

_____

Were any photographs taken of you or the accident scene? If so, by whom: _____

_____

Identify any medics/fire departments: _____

Eyewitness - name, address, phone:

_____

_____

_____

VI. Description of the Injury Sustained:

What part's of your body was injured in the accident?

_____

What part's of your body still cause you discomfort?

_____

Describe in detail all injuries you are claiming from the accident:

_____

_____

_____

_____

Were you examined at a hospital — name, address, date(s):

_____

_____

List all health care providers who treated you for injuries from the collision — name, address, date(s):

_____

_____

_____

_____

_____

_____

Do you have any medical bills? Please provide copies: _____

Do you have any medical records? Please provide copies: _____

Any photographs, videotapes, etc. of your injuries, if so please provide copies: _____

Any diaries or notes concerning your injuries, if so please provide copies: _____

VII. Pre-existing Medical Conditions:

Have ever been treated by any health care provider for any pre-existing condition to the same body parts that were injured in this accident? If so please state the name, address and dates of

treatment for each health care providers who treated you for injuries for the pre-existing condition - name, address, date(s):

_____

_____

_____

List all previous medical conditions — nature and dates (not referenced above):

_____

_____

List all health care providers who treated you for these prior medical conditions prior to the collision:

_____

_____

VIII. Prior Suits & Claims:

List all prior insurance claims regarding any type of automobile accidents, boating accidents, worker's compensation claims and/or homeowner's claims including the nature, circumstances and dates:

_____

_____

IX. Second Injury Fund Claim Information:

Have you ever sustained an injury (either work related and not work related) to another part of your body (i.e. back, neck, knee, hands, etc.), and if so for each injury please state:

Date of Prior Injury: _____

Part of Body Previously Injured: _____

_____

State the Percentage of Disability Assessed (if any): _____

X. Death Claims:

Did the work related injury result in death, and if so please provide the following dependent information.

Dependent Information:

Name	Date of Birth	Relationship	Extent of Dependency

XI. Additional information:

Do you need additional medical treatment? _____

What type of additional treatment do you need? _____

_____