

LAW OFFICES OF ROBERT T. BLEDSOE  
***DATA INPUT INFORMATION FORM***

This information form will allow us to create a data base and an initial computer file assisting us to efficiently continue with the 'Intake' process and procedures.

**REMEMBER TO SAVE THE DOCUMENT AFTER FILLING IT OUT**

*PLEASE ENTER ALL INFORMATION IN THE FIELDS PROVIDED*

1) Title: Mr. \_\_\_\_\_ Ms. \_\_\_\_\_ Mrs. \_\_\_\_\_      2) Email: \_\_\_\_\_

3) First Name: \_\_\_\_\_

4) Middle Initial: \_\_\_\_\_

5) Last Name: \_\_\_\_\_

6) Mailing Address: \_\_\_\_\_

7) City, State, Zip code: \_\_\_\_\_

8) Primary \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

9) WC Insurance Carrier: \_\_\_\_\_

10) Claim Adjuster's Name: \_\_\_\_\_

11) Ins. Company Address: \_\_\_\_\_

12) City, State, Zip code: \_\_\_\_\_

13) Carrier's phone #: \_\_\_\_\_

14) Claim Number(s): \_\_\_\_\_

15) Date of Injury: \_\_\_\_\_

16) Body part Injured: \_\_\_\_\_

17) Your Date of Birth: \_\_\_\_\_      18) Social Security Number: \_\_\_\_\_

19) Employer: (at time of injury) \_\_\_\_\_

20) Employer's Address: \_\_\_\_\_

21) City, State, Zip code: \_\_\_\_\_

22) Job Title: \_\_\_\_\_ WCAB Number: \_\_\_\_\_

23) Primary Doctors Specialty (ie: Chiropractor): \_\_\_\_\_

## WORKERS' COMPENSATION QUESTIONNAIRE

Please PRINT your answers to the following questions; answering ALL questions in order for us to fully evaluate your need for legal representation and assistance with any Workers' Compensation claims. *If your need additional space to fully answer a question simply use the reverse side of the page indicating the question's number/letter and continue printing your complete answer to the question asked.*

### 1 GENERAL INFORMATION:

Your Legal Name: \_\_\_\_\_, \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

How did you hear of our office? \_\_\_\_\_

Your current mailing address: \_\_\_\_\_  
(Street or POB, city, state, zip code)

Physical address, if different than your mailing address: \_\_\_\_\_  
\_\_\_\_\_

Your HOME phone number(s): (Area code) \_\_\_\_\_ / \_\_\_\_\_

Your CELL phone number: (Area code) \_\_\_\_\_ EMAIL: \_\_\_\_\_

Please list an additional contact person (*not living with you*) that we could call or contact in cases of urgency or emergency:

Name: \_\_\_\_\_ relationship; \_\_\_\_\_

Their Address: \_\_\_\_\_

Phone Number(s), Email and/or other contact information for this person: \_\_\_\_\_

### 2 EMPLOYMENT INFORMATION:

*(Provide your employer's information where you were working at the time of the injury)*

Name of your Employer or Company: \_\_\_\_\_

Address of the Employer or Company: \_\_\_\_\_

Address of where you worked, if different from Employer's address; also list the department or division in which you worked: \_\_\_\_\_  
\_\_\_\_\_

Phone number(s) of your employer if known: \_\_\_\_\_

Your job title: \_\_\_\_\_ Date you were hired: \_\_\_\_\_

Wages/Salary you received: \$ \_\_\_\_\_ Hourly Weekly Monthly Annually

Did you work full time? Yes, 40 hours per week No, if worked only part time: how many hours per week? \_\_\_\_\_

Did you work regular Overtime? Yes No If yes, how many average hours of Overtime per week? \_\_\_\_\_ Rate: \$ \_\_\_\_\_

Do you belong to a Union? Yes No If yes, list name and local #: \_\_\_\_\_

Were you scheduled for a wage increase/raise, work review and/or cost of living wage increase? Yes No  
If yes, please explain why and the amount of increase: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly explain your regular job duties and describe the job you were doing at the time of injury:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you have a second job that you were working at the time of your Industrial Injury? Yes No  
If yes,

Second Employer's Name and Address: \_\_\_\_\_

Job Title: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Wages: \$ \_\_\_\_\_

Average number of hours worked per week on your second job? \_\_\_\_\_

Job duties of your second job: \_\_\_\_\_

PAST EMPLOYMENT HISTORY:

What 'other' employers or companies have you worked for during the last 2 years? NONE

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

How long did you work there? \_\_\_\_\_ Pay rate: \$ \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

How long did you work there? \_\_\_\_\_ Pay rate: \$ \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

How long did you work there? \_\_\_\_\_ Pay rate: \$ \_\_\_\_\_ Job Title: \_\_\_\_\_

Are you NOW working with a different Employer or Changed Jobs since your date of injury?  Yes  No  
If yes,

New Employer: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of hire: \_\_\_\_\_ Job Title: \_\_\_\_\_ Rate of pay: \$ \_\_\_\_\_

How much time have you missed at work? (List the exact dates, periods or time frames you have been off work due to the industrial injury): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3 INJURY INFORMATION:**

*IF more than one date of injury -Please answer the following questions for each date of injury on back of this page.*

Body part(s) injured: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Where did the injury occur? (I.E., Employer's address, On the road, In the field - Include City and Zipcode)

How did the injury occur? What happened?  
\_\_\_\_\_  
\_\_\_\_\_

Did any other person(s) witness the accident or injury?  Yes  No  Don't know or unsure

If yes, explain who and list name(s): \_\_\_\_\_  
\_\_\_\_\_

Do you feel that another person(s), faulty machinery, equipment / device malfunction, or an unsafe / improper work environment was responsible for your injury?  Yes  No  Unsure or don't know

Comments: \_\_\_\_\_  
\_\_\_\_\_

Briefly describe how your injury occurred and what happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you report the injury?  Yes  No If Yes, who did you report the injury to? \_\_\_\_\_  
If No, why? \_\_\_\_\_

Did the employer or company complete or fill out a claim form or accident report?  Yes  No  Don't Know/Unsure  
Did the employer provide you with a completed or filled out copy of a Workers' Comp. claim form?  Yes  No  
Do you have a copy of that form to provide to us for review and placement into your file?  Yes  No

**4 PRIOR INJURIES**

HAVE YOU HAD ANY OTHER PRIOR INDUSTRIAL OR WORKERS' COMPENSATION INJURIES?  Yes  No  
If yes, please list details: *(Continue on back of this page if more space is needed to answer this question)*

Body Part                      Date of Injury                      Employer                      City and State where occurred

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do any of these injuries still bother you?  Yes  No  
Do you have permanent 'Work Restrictions' from prior injuries?

Did any of the prior injuries cause permanent disability?  
\_\_\_\_\_

Are you still receiving and medical treatment or taking prescription medication for the ABOVE prior industrial injuries?  
Comments or Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did you receive any monetary settlements for any prior Industrial or Workers' Compensation injuries?  Yes  No  
If yes, provide some details: *(List the injury, date of injury, body part involved, type of settlement and the rating, if known)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5 MEDICAL INFORMATION RELATING TO YOUR WORK INJURY OR ILLNESS:**

When your injury first occurred, did you receive immediate medical care? Were you taken the hospital emergency room, or go to a doctor or clinic? Did you receive 'on-site' first aid or assisted by company 'in-house' medical personnel? Answering the above, please explain details of medical care received immediately after your workplace injury with names of doctor(s), clinic and / or name and location of hospital:

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Are you still seeing your doctor and receiving medical care?  Yes  No

Who is your current treating physician?

Doctor's Name and/or Clinic: \_\_\_\_\_ City: \_\_\_\_\_

Other comments: \_\_\_\_\_

Who sent you to your current treating physician?  Employer  Insurance Co.  Personal choice

Other: \_\_\_\_\_

If you were required to select your current doctor, did you select your doctor from:

A list or referral form you received from the insurance company.

A referral from another doctor or medical professional.

A personal referral or personal knowledge of the physician.

Do you plan on staying with your current Doctor during the course of your treatment? (Are you happy with this Doctor?)

Yes  No, I would like to request a change of treating physician, because:

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Have you had surgery for this injury?  Yes  No Has surgery been recommended or schedule?  Yes  No

Has the Doctor found you Permanent & Stationary, or released you to return back to work?  Yes  No

Do you have any type of medical insurance, either employer-provided group medical coverage or your own private medical insurance?  Yes, (Name of Company) \_\_\_\_\_

(Medical Number) \_\_\_\_\_

No

Who has been paying for your medical treatment, tests & medicines relating to your work injury?

Workers' Comp.  Yourself  Your own medical insurance or your Spouse's Ins.  Medi-Cal  Lien basis

Other, explain \_\_\_\_\_

Have you or are you currently having any problems getting the medical bills paid or problems with receiving authorization for medical treatments, tests and/or medications prescribed by your treating physician?  Yes  No

Comments: \_\_\_\_\_

Have you been given a selection of QME's (Qualified Medical Evaluators) or a form listing evaluating Doctors for you to choose and see?  Yes  No If yes, did you select a QME?  Yes  No If you selected a QME from the panel what was their name? \_\_\_\_\_

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Did you have the evaluation or appointment with the QME doctor?  Yes  No When? Date \_\_\_\_\_

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**6 OTHER MEDICAL INFORMATION:**

Who is your primary care physician or your family Doctor? (Dr.'s Name, Clinic Name, Address, City/State)

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Do you have any serious illnesses? (I.E., diabetes, asthma, arthritis, cancer)  Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any prior surgeries or been hospitalized?  Yes  No

If yes, explain listing dates, place and reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any 'non-industrial' injuries, such as car accidents, broken bones, sports injuries, childhood accidents or serious childhood illnesses?  Yes  No

If yes, explain listing dates, body part(s) and/or type of serious illness: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any disability, pain, limitations or continued medical problems from the above prior injuries?

Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**7 INSURANCE INFORMATION:** *(regarding your current work injury)*

What is the name of the Insurance Company (Workers' Comp. Carrier) handling this work injury for your Employer?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

The claim's adjuster or contact person at the insurance company: \_\_\_\_\_

Has the insurance company or their attorney contacted you either by phone or letter?  Yes  No

If yes, do you remember when and who you talked with?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the adjuster, investigator, or an attorney taken a statement from you regarding the injury?  Yes  No

If yes, what do you remember about the questions and your answers (or any other comments you would like the attorney to know): \_\_\_\_\_  
\_\_\_\_\_

Has the insurance company or their representative have you sign any type of document(s)?  Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has anyone representing this insurance company offered any type of proposed settlement?  Yes  No

If yes, explain: \_\_\_\_\_

Have you received any payments or checks identified as 'Permanent Disability' (PD), or 'Permanent Partial Disability' (PPD), or 'Permanent Disability Advance' (PDA)?  Yes  No

If yes, approximately how much money in permanent disability checks have you received thus far? \$ \_\_\_\_\_

**8 OTHER REQUIRED INFORMATION:**

**Disability Payments:**

*Temporary Disability (TD) payments*

How much work time have you missed because of your work injury? \_\_\_\_\_

Are you still off work per doctor's orders?  Yes  No

Did you receive Temporary Disability Payments?  Yes  No

Have you been paid for ALL the time you missed from work thus far?  Yes  No

If you received TD, what was the weekly amount paid? \$ \_\_\_\_\_

Are you receiving these TD payment currently?  Yes  No

If NO, when did they stop? \_\_\_\_\_

Do you know the reason disability payments have stopped? \_\_\_\_\_

*State Disability Insurance (SDI) payments.*

Are you receiving SDI benefits currently?  Yes  No

If yes, the amount being paid weekly: \$ \_\_\_\_\_

Did you ever apply for SDI payments because of this work injury?  Yes  No

Comments: \_\_\_\_\_

Have you applied and/or received or currently receiving any other benefits related to your work injury? Such as accrued vacation time/pay, sick time/pay or Social Security, SSI, retirement benefits, Long Term or Short Disability payments, salary continuation, or any other payments because of your industrial injury or illness....Please explain or comment regarding other benefits or funds:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Attorney contact(s):**

Have you consulted with another attorney about this work injury or illness before today?  Yes  No

If yes, please provide the attorney's name and address: \_\_\_\_\_

Reason for the prior consultation with another attorney:

*(such as Third Party, Wrongful Termination, Discrimination, Faulty equipment, machinery or tools, medical malpractice or for advice on this Workers' Compensation claim)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did you agree to representation or sign ANY paperwork?  Yes  No

Have you filed with EEOC or an ADA Claim?  Yes  No if yes, explain:

\_\_\_\_\_

\_\_\_\_\_

Have you filed a Union grievance?  Yes  No if yes, explain: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL SECURITY**

Have you applied for Social Security Disability Insurance (SSDI)?  Yes  No

If yes, what is the status of your claim? \_\_\_\_\_

\_\_\_\_\_

Are you currently receiving Social Security Disability Insurance (SSDI) payments?  Yes  No

If yes, are you receiving Medicare?  Yes  No

Comments, if any: \_\_\_\_\_

**ENGLISH LANGUAGE**

Is English your primary language?  Yes  No if No, What is your primary language: \_\_\_\_\_

If English is not your primary language, do you feel you will need an interpreter for legal proceedings?  Yes  No

*Please Note:*

**If you feel you do not read, speak and write in English effectively an interpreter can be arranged for legal proceedings, depositions and medical evaluations...BUT understand you will be required to bring a friend, family member or another person with you for all of your meetings with your attorney or other contacts with this office that is able to efficiently speak, read and write English, You must also provide a name and phone contact of someone speaking English that this office could contact by phone regarding your case.**

Please sign in agreement: \_\_\_\_\_

Name of person(s) to contact that will assist in translation:

\_\_\_\_\_

Relationship: \_\_\_\_\_ Their phone number(s): \_\_\_\_\_

Any other contact information that would enable this office to communication with you: \_\_\_\_\_

\_\_\_\_\_

Do you have any other 'IMMEDIATE' concerns or urgent questions you need answers to?

\_\_\_\_\_

\_\_\_\_\_

You may use this space for other information not covered within the questionnaire or any facts that you wish the attorney to consider and be contained your file:



1) Are you currently working?      Yes      No

2) If not, when was the last time you worked? \_\_\_\_\_

3) If the last time you worked it was for a different employer than the one you are filing the claim against, please provide their name here:

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