CLIENT INTAKE FORM
LAW OFFICES OF POMPER & DETTENHAIM

Mr. Ms. First _____ Middle ___ Last _____
(circle one)

Street Address: _____

City: _____ State ____ Zip _____

Home Phone: _____ Work Phone: _____

Cell: _____ other phone: _____

Social Security #_____ Date of Birth ___/___/____

Drivers' License or other ID # _____

Language spoken: _____ Interpreter needed? _____

Can you: (please circle) read English Yes No write English Yes No

Union Member? Yes No Local #: _____ Business Agent _____

How did you hear about us? (circle one) friend doctor yellow pages other_____

If someone referred you, what is their name? _____

Why are you seeking assistance from a lawyer? _____

_____

_____

_____

Name of Employer, when the injury occurred: _____

Employer Address: _____

_____

Phone: _____ Fax: _____

Date you started working there: _____

Are you still working for this same employer? Yes No

If no, what was the last date you worked for this employer? _____

If you are no longer working there, what is the reason? _____

_____

Is it because of your injury? Yes No

Did your employer let you work for a while after your injury? _____

Was it your regular job, or a modified or alternate job? _____

Have you missed work because of the injury? Yes No If you missed work, what are the dates you missed work?

_____

Please list your previous jobs for the last 10 years: (write on the back of this page if needed)

Job Title:	Dates of Employment	Employer	Job Duties	Reason for leaving

What date did you notify your employer of your injury? _____

Who did you give notice to? _____

Was notification verbal or written? _____ Were you given a claim form? Yes No

What date was your claim form filled out? _____ Were you given a copy? Yes No

Were you laid off or fired *before* you made your claim? (circle one) Yes No I don't know

Were you laid off or fired *after* you made your claim? (circle one) Yes No I don't know

Has your claim been denied by the insurance company for the employer? Yes No I don't know
If yes, when was it denied? _____

INSURANCE COMPANY INFORMATION (for the Workers' Compensation Insurance Co.)

Name of company: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____ Fax: _____

Claims/Adjustor name: _____

Claim number(s): _____

Are you, or were you, represented by an attorney? (circle one) Yes No

Name:_____

Address: _____

City/State/Zip: _____

Phone: _____

Did you sign papers with that attorney? (circle one) Yes No I don't know

_____

DUTIES AND EARNINGS AT TIME OF INJURY:

Job title at time of your injury: _____

Typical job duties: _____

Earnings: hourly $ _____ hours per day/week/month? _____ overtime? _____ OT rate of pay $ _____

Did you receive: tips, bonuses, commissions? _____

Did you receive allowance for travel expense? Housing? Laundry? Other? _____

Explain: _____

_____

DESCRIPTION OF INJURY:

Date of injury(ies) _____ time of injury _____

Was there more than one date of injury? Yes No If yes, please see following page.

Did your injury occur on one date or over a period of time? _____

Describe in detail what occurred: _____

_____

_____

Body parts injured: _____

_____

Was it at the same address as the employer, or on a location away from the employer's address? Describe:

_____

Witnesses? Yes No Names: _____

SEE FOLLOWING PAGE IF MORE THAN ONE DATE OF INJURY:

If there was more than one date of injury, please list dates and the following information:

Date of Injury	Part(s) of Body injured	How did injury occur?	Name/address/phone number employer

Please use the back of this page if necessary.

_____

Issues related to 3rd party personal injury claims, 132(a), Serious and Willful, or other labor-related action:

Do you believe your employer fired you or discriminated against you in any way because you pursued medical treatment for your work-related injury? Yes No Please explain: _____

_____

_____

Did your injury occur because of a motor vehicle accident? Yes No Please explain: _____

_____

_____

If so, do you have an attorney representing you with regard to the motor vehicle accident? Yes No

Name: _____ Phone _____

Address: _____

City/State/Zip: _____

Did you already receive a settlement? Yes No Amount $ _____

Do you feel that your injury was caused by a dangerous condition at work? (for example: an unlit stairway, slippery floors, a hole in the ground or floor, exposed power lines) Yes No Please explain:

_____

_____

Were you exposed to chemicals, hazardous materials, other substances? Yes No Please explain:

_____

_____

Is there a hazardous nature to your job? For example, do you work with chemicals, or explosives, or do you work at great heights? Yes No Please explain: _____

_____

Do you feel your injury was caused by a co-worker? Yes No Please explain: _____

_____

Do you feel your injury was caused by someone other than your employer, or by a co-worker? If so, please describe how the other person was at fault: _____

_____

At your workplace, were you sexually harassed, or discriminated against due to age, race, sex, religion, or sexual orientation? When? By whom? Please describe: _____

_____

_____

Was information posted at your job, and/or, were you given written notice explaining what to do in case of a work-related injury? Yes No Describe: _____

Was there an OSHA investigation related to your injury or your workplace? Yes No I don't know Describe: _____

_____

MEDICAL TREATMENT FOLLOWING THE INJURY

Have you seen any doctors for your injury? Yes No If yes, please list:

Name _____ Name _____

Address_____ Address _____

_____ _____

Phone: _____ Phone _____

_____

Name _____ Name _____

Address_____ Address _____

_____ _____

Phone: _____ Phone _____

Have any diagnostic tests been performed: (X-rays, MRI, CT SCAN, EEG, EMG, nerve conduction, etc.)
If yes, what was performed, and where? _____

_____

_____

Who paid for these tests? (circle one) Workers' Compensation Employer Personal health insurance
Spouse's insurance Medicare I am being billed I don't know Other_____

Have you been hospitalized for this injury? If yes, where and when: _____

_____

Have you had surgery for this injury? If yes, where and when: _____

_____

Who paid for surgery? (circle one) Workers' Compensation Employer Personal health insurance
Spouse's insurance Medicare I am being billed I don't know Other_____

Please list any doctors or hospital visits or other treatment not paid for by workers' compensation:

_____

_____

Are you a Kaiser member? Yes No
Have you had any industrial treatment in any Kaiser facility for this injury? Yes No

If yes, where? _____

Have you been released from medical care for this injury? Yes No

Have you been released to go back to work? Yes No Who is the doctor who released you back to work? _____ Have you returned to work? Yes No

Are you working now? Yes No Are you with the same employer? Yes No

If you are not with the same employer, who do you work for now? _____

Were you fired after you were released to return to work? Yes No

If yes, what was the reason given by your employer? _____

_____

BENEFITS

Please list all benefits that you have received following your injury; please list ALL that apply:

TYPE	AMOUNT/WEEK	PAYMENT START/FINISH DATE
Temporary Disability		
State Disability		
Payroll Continuation		
Social Security: type:_____		
Unemployment		
Private Long or Short-Term disability		
Veteran's Benefits		
Settlement from Another claim		

PRIOR INJURIES, CLAIMS, CONDITIONS

List **prior** workers' compensation claims:

#1 Body parts _____

Date of injury(ies) _____ Employer: _____

Settlement? (circle one:) Compromise and Release Stipulations with future medical I don't know

Treating physician for this claim: _____

Insurance carrier: _____ Claim # _____

#2 Body parts _____

Date of injury(ies) _____ Employer: _____

Settlement? (circle one:) Compromise and Release Stipulations with future medical I don't know

Treating physician for this claim: _____

Insurance carrier: _____ Claim # _____

Please use the back of this page if necessary.

How was your health prior to this injury? Excellent Good Fair Poor

Before your work-related injury, have you been diagnosed with any of the following?

High blood pressure Yes No
Hypertension Yes No
Diabetes Yes No
Heart problems Yes No
Lung problems Yes No
Hearing problems Yes No
Hip/knee problems Yes No
Back/neck problems Yes No
Hand/wrist problems Yes No
Arm/shoulder problems Yes No
Multiple sclerosis Yes No
Rheumatoid arthritis Yes No
Fibromyalgia Yes No

If the current injury is stress-related, have you received treatment before this date of injury for any psychiatric or stress-related problems? Yes No Explain: _____

_____

Have you ever had chiropractic treatment? Yes No If yes, when, and for what condition? _____

_____ Name of chiropractor: _____

Address _____

City/State/Zip _____

_____

OTHER CLAIMS THAT ARE NOT RELATED TO WORK

Have you ever been in a motor vehicle accident? Yes No When? _____Were you injured? Yes No

If yes, what body parts were injured? _____

Did you receive treatment? Yes No Where? _____

Was there a settlement? _____ Describe: _____

Have you ever been involved in a personal injury claim? Yes No When? _____

Explain: _____

Did you receive treatment? _____Where? _____

Was there a settlement? _____ Describe: _____

_____

VOCATIONAL REHABILITATION

Have you received information regarding your rights to vocational rehabilitation? Yes No

Are you receiving vocational rehabilitation benefits or services? Yes No

If yes, when did services or benefits start? _____ Did they end? Yes No

Who is your vocational counselor? Name:_____ Company_____

Are you in any school or training program at this time? Yes No

If yes, explain: _____

When are vocational services or training due to end? _____

Have you requested an interruption? Yes No

I swear that the above information is complete, true, and correct to the best of my knowledge.

_____

Signature

_____

Name, printed

_____

Date

If you needed assistance with filling out this form, what is the name of the person who helped you:

_____

Relationship: friend spouse relative