

LAW OFFICE

INTAKE SHEET

PERSONAL INJURY/WORKERS COMPENSATION

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

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

Co-Prospect Name: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Prospect Home Phone: \_\_\_\_\_

Prospect Work Phone: \_\_\_\_\_

Prospect Cell Phone: \_\_\_\_\_

Prospect E-Mail: \_\_\_\_\_

Co-Prospect Home Phone: \_\_\_\_\_

Co-Prospect Work Phone: \_\_\_\_\_

Co-Prospect Cell Phone: \_\_\_\_\_

Co-Prospect E-Mail: \_\_\_\_\_

Prospect Employer/Former Employer: \_\_\_\_\_

Prospect Employer Address: \_\_\_\_\_

**LAW OFFICE**

Co-Prospect Employer/Former Employer: \_\_\_\_\_

Co-Prospect Employer: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Was this work related:  Yes  No

Is there a police report:  Yes  No

If so, do you have a copy:  Yes  No

**\*\*IF A POLICE REPORT IS AVAILABLE, PLEASE PROVIDE  
IT WITH THIS INTAKE SHEET\*\***

Please describe how the injury occurred:

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

Was there property damage:  Yes  No

If so, please provide details including property description and estimated damages:

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

**LAW OFFICE**

Were you injured:  Yes  No

If so, please provide details including body parts and any specific diagnosis provided by a physician:

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Have you seen a physician or medical provider for your injuries:  Yes  No

If so, please provide dates and names of physicians seen along with a description of the treatment received:

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Have you ever had any prior personal injury cases:  Yes  No

If so, please provide dates, description of the case, type of injury, if a lawsuit was filed, if you received a settlement, and what was the settlement:

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**LAW OFFICE**

Have you ever had any prior workers compensation cases:  Yes  No

If so, please provide dates, description of the case, type of injury, if you received a permanent disability rating, if you received a settlement, and what was the settlement:

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Have you seen a physician or medical provider for any prior injuries to the same body parts that were injured in this accident:  Yes  No

If so, please provide dates and names of physicians seen along with a description of the treatment received:

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Did you lose any time from work?  Yes  No

If so, how much time have you missed?

How long have you been employed: \_\_\_\_\_

Annual Gross Salary: \_\_\_\_\_

Are you married:  Yes  No

If so, did your spouse lose any time from work due to your accident:  Yes  No

## LAW OFFICE

If so, how much time has your spouse missed? \_\_\_\_\_

How long has your spouse been employed at their employer: \_\_\_\_\_

Annual Gross Salary: \_\_\_\_\_

Please provide details of any other damages and details regarding your accident:

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**OFFICE USE ONLY**

Retainer:  H  C  C7  C13  CR  EP  FF  WC  Other \_\_\_\_\_  PPL

Case Information Sheet:  BK  BK LIT  CIV LIT  EP  EMP  WC  PI-GEN  PI-MV

Other Forms:  CIS  COI  CA  NCA

523 Issues: \_\_\_\_\_  Delay in Filing: \_\_\_\_\_ BE Name: \_\_\_\_\_

Key Issues: \_\_\_\_\_

SOL: \_\_\_\_\_ Misc Deadlines: \_\_\_\_\_