

Law Offices of  
McCARTHY, CALLAS, FUHR & ELLISON, P.C.  
Workers' Compensation Questionnaire

**NAME:** What is your first name, middle initial, and last name?

**MAILING ADDRESS:** What is your mailing address, including your zip code?

**TELEPHONE NUMBER:** What is your telephone number, including the area code?

**SOCIAL SECURITY NUMBER:**

**DATE OF BIRTH:**

**AGE ON D/A:**

**MARITAL STATUS:** On the date of this injury were you married, single, widowed, divorced or separated? If married, state the name of your spouse.

**CHILDREN:** As of the date of this injury, please set forth the names and ages of your children who were then under eighteen years of age.

**EMPLOYER:** Set forth the accurate **name and address** of your employer at the time of this injury. If possible, please attach a paycheck stub from that employer.

**DATE OF ACCIDENT:** What was the **exact** date and **time** which your injury occurred?

**LOCATION OF ACCIDENT:** In, or near, what town were you working at the time of your injury?

**DESCRIPTION OF ACCIDENT:** Briefly describe how you got hurt.

**NAME AND ADDRESS OF EMPLOYER'S WORKER'S COMP. INSURANCE CARRIER:**

**IMMEDIATE DISABILITY:** Were you immediately disabled at the time of this injury?

**NOTICE:** Identify by **name and position**, and on what date you first told a supervisory employee (lead man, foreman, superintendent, plant nurse, plant doctor) what happened when you were injured and how the injury occurred.

**PHYSICIANS:** List the **names and addresses** of the physicians who have treated you. Also set forth the periods of time during which each rendered treatment.

**HOSPITALS:** List the **names and addresses** of the hospitals where you received treatment. Also, set forth each period of time during which you were hospitalized.

**NATURE OF INJURY:** What did the doctors say the nature of your injury was? When possible, please refer to the right or left side of your body, or refer to the right or left member involved.

**TREATMENT:** Briefly describe the treatment which has been rendered. If you have had surgery, what was the **date** of the surgery and what was the nature of the surgery. If casts were used, to what part of your body were they applied, and over what periods of time were they used? If braces were used, to what part of your body were they applied, and over what periods of time were they used?

**FURTHER TREATMENT:** What further treatment is planned. If further surgery is planned, what is the nature of that surgery, and on about what date is it scheduled?

**RIGHT HANDED:** Are you right handed?

**OCCUPATION:** On the date of this injury, what was your occupation?

**HOURLY WAGE:** On the date of this injury, what was your hourly rate of pay? What was your **average** hourly or weekly income for the twelve month period immediately prior to your injury (Gross weekly wage)

**PIECE WORK:** If you were paid on a piecework basis, rather than at an hourly rate, then, on the **average**, for a forty hour week, not including overtime, what was your weekly wage before any deductions?

**LENGTH OF EMPLOYMENT:** On what date did you first start to work for this employer?

**PLACE OF ORIGINAL EMPLOYMENT:** Where, (in what town) did you first start to work for this employer?

**LOST TIME:** Using dates, please set forth the period, or periods, of time during which you were off work on account of this injury.

**RELEASE FROM WORK:** On what date did the doctor first give you permission to return to work?

**COMPENSATION PAID:** If you were paid lost time compensation, at what weekly rate was payment made, what period of time was covered by those payments, and what was the total amount paid?

**PRIOR INJURIES:** Before the date of this injury, had you ever hurt the same part(s) of your body as those now injured? If so, with respect to each such prior injury, relate when the injury occurred, where it occurred, whether you were working when injured, and if so, the name of your employer at that time; describe the manner in which the injury occurred, set forth the names and addresses of the physicians who treated you, set forth the names and addresses of the hospitals in which you were a patient, and describe the nature of the injury.

**PRIOR MEDICAL CARE:** Before the date of this injury, regardless of whether you had sustained an accidental injury involving the same part(s) of your body, had you ever had medical care directed to those part(s) of your body? If so, set forth the names and addresses of the physicians who treated you, set forth the names and addresses of the hospitals in which were a patient, and describe the nature of the ailment for which you were treated.

**PRIOR DISABILITIES:** Before the date of this injury, was there anything wrong with the same part(s) of your body as those which have been injured in this accident? If so, what part of your body was involved and what was the problem?

**VETERAN STATUS:** Are you a veteran? What branch of the military service?

**MEDICAL DISCHARGE:** Did you receive a medical discharge?

**SERVICE DISABILITIES:** If you received a medica discharge, what disabling condition was the basis for that discharge?

**DEFERRED STATUS:** If you are not a veteran, why were you deferred?

**SUBSEQUENT INJURIES:** Since the date of this injury, have you, at any time, hurt the same part(s) of your body as those involved in this injury? If so, with respect to each such subsequent injury, relate when the injury occurred, where it occurred, whether you were working when injured, and if so, the name of your employer at the time; describe the manner in which the injury occurred, set forth the names and addresses of the hospitals in which you were a patient, and describe the nature of the injury.

**PRESENT PHYSICAL COMPLAINTS:** What physical complaints do you now have, which you feel are a result of the injury at work which you described on page one of this questionnaire? Please be reasonably specific when answering this question.

**INDUSTRIAL COMMISSION INFORMATION HANDBOOK:** (Illinois only) Were you given an Industrial Commission Information Handbook by your employer?

**IF THE WORKER'S COMPENSATION INSURANCE CARRIER HAS NOT PAID YOUR MEDICAL BILLS, PLEASE LIST ALL UNPAID BILLS BELOW** with name, address, dates of service and amount: If any of these bills have been paid by any other source, please also list that source.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_