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WORKERS' COMPENSATION INTAKE FORM

PERSONAL INFORMATION

Client's E-Mail: _____

Name: _____

Address: _____ City: _____

State: _____ Zip: _____

Telephone: _____ (home) _____
_____ (work or cell)

_____ (friend/relative) _____
(spouse work or cell)

Date of Birth: _____ SSN: _____

Height: _____ Weight: _____

Dominant Hand: Right _____ Left _____

Spouse _____ Date of Marriage: _____
(Name) (DOB)

Tax Filing Status: _____

Dependents/Children:

(Name) (DOB) (Name) _____
(DOB)

(Name) (DOB) (Name) _____
(DOB)

Level of Education: _____

Military Service: _____
(Dates of Service) (Rank)

(Awards/Medals)

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Have you ever been arrested and/or convicted of any crimes? _____

If yes, please explain: _____

Are you a U.S. citizen? _____ If no, what is your legal status? _____

Medicaid or other health insurance paid medical for injury? _____

Friend of the Court Lien? _____ If yes, where and how many? _____

EMPLOYMENT HISTORY

Name of Last/Current Employer: _____

Address: _____

Telephone Number: _____

Dates of Employment: _____

Job Performed: _____

Hourly Rate: _____ No. Hours Per Week: _____

Yearly Income: _____

Do you have a second job? _____

If yes, answer the following:

Name of Employer: _____

Address: _____

Telephone: _____

Dates of Employment: _____

Job Performed: _____

Hourly Rate: _____ No. Hours Per Week: _____

Yearly Income: _____

Please list the name of each employer, their address, the dates of your employment, your hourly rate/salary, and your job title for each employer you have had for the last 10 years.

INJURY INFORMATION

Date of Injury: _____

Where Injury Occurred: _____

How did injury occur? _____

Any witnesses to the injury? _____

Last day worked? _____

Are you still working? _____ yes _____ no

Full time _____ Part time _____ Regular job _____ Light/restricted duty _____

Are you at a restricted wage? _____ yes _____ no

Regular wage _____ Reduced wage _____

Were comp benefits voluntarily paid after injury? _____

Were they stopped? _____ If yes, why? _____

Weekly rate \$ _____

Was there a wage continuation plan? _____

List all doctors, hospitals, or other medical professionals seen for this injury:

List restrictions and doctor who authored them: _____

List any hospital/treatment facility where surgery or testing (MRI, CT Scan, EMG) was performed and date same was performed: _____

List all injuries (back, neck, arms, etc.): _____

What makes the pain worse? _____

What makes the pain better? _____

Have you been injured before? _____ yes _____
no

If yes, list the injuries and dates injured: _____

Have you ever received or filed for workers' compensation benefits before? _____

Have you ever made a claim for other injuries before? _____

