FOSTER LAW

T (206) 682-3436
F (206) 682-3362
E info@FosterLawPC.com
8204 Green Lake Drive N.
Seattle, WA 98103
www.FosterLawPC.com

WORKER'S COMPENSATION QUESTIONNAIRE

Thank you for contacting our office regarding your industrial injury or occupational disease. In an effort to better understand the issues involved in your claim and identify all benefits to which you may be entitled, please fully answer the following questions. We understand that some of the questions may seem to pry into your personal life. However, to be of greatest assistance to you, it is vital that we have a complete and accurate understanding of you and your claim. Any inaccuracies or less than truthful responses could impair our ability to provide you appropriate legal advice and result in the loss of a claim you may have for further benefits. Rest assured ***all*** information you provide to Foster Law, P.C. is confidential and will not be disclosed to third parties.

Today's Date _____

Referral Source _____
If a person, may we send a thank you note referencing your name? _____

Name _____ Home Phone _____

Address _____ Cell Phone _____
_____ Date of Birth and Age _____
_____ SS No. _____

E-mail _____ R/L Handed _____

Height/Weight _____ Gained or lost weight since injury? _____
Marital Status _____ Spouse's Name _____
Spouse's Occupation _____

Dependents and Birth Dates _____
_____

Permanent/Emergency Contact _____
Name Phone

CLAIM DATA/STATUS

Claim No. _____ Claim Manager _____
Has claim ever been closed? _____ If so, date closed _____

Describe any permanent disability awarded in claim closure _____
_____

Is claim currently open or closed? _____
Have you met with a vocational counselor? _____ If so, name _____
Purpose of vocational meeting as you understand it _____
_____

Accepted Conditions _____
Denied Conditions _____

Have you received time loss? _____Amount per check (every 14 days) _____
Last date received_____

Have you attended an "Independent Medical Examination"? _____
If so, what was/were date(s) of IME? _____

Have you been denied medical treatment for your injury/disease? _____
If so, what treatment have you been denied? _____

Has anyone other than L&I paid for medical bills? E.g., private medical insurance, Medicare, DSHS?
If so, who and for what treatment? _____
_____

Describe any benefits/assistance you are currently receiving outside of this claim? E.g., SSD, SSI, unemployment, private disability policy? Describe the benefits and how long you have received them. _____ _____
_____

What are your current concerns with your claim/Why are you seeing an attorney at this time?
_____
_____
_____
_____
_____

ACCIDENT/DISEASE DETAIL

Employer at time of injury _____
Employer's address _____
_____

Position/Job Duties _____
_____
How long were you employed with this employer at the time of the injury or disease? _____

Wage/Salary _____ Did you normally work overtime? _____
If so, how often _____
Did you receive any bonuses? _____ If so, how much and how often? _____
Did employer provide health care benefits? ____ Has employer terminated such benefits? _____
If so, when? _____

Were you working more than one job at time of injury or receiving other income? _____
If so, list all other income sources _____
_____

Date of Accident/Disease _____ Time _____
Place of Accident _____
What Happened? _____
_____
_____
_____
List witnesses _____
_____
_____
Describe injuries/disease sustained _____
_____
_____
Describe current problems _____
_____
_____

List medical providers seen for claim related condition(s) (AP/Surgeon/Consultation/Helpful/Not Helpful)

( ) _____ ( ) _____
( ) _____ ( ) _____
( ) _____ ( ) _____
( ) _____ ( ) _____
( ) _____ ( ) _____

Do you have private medical insurance?_____
List all current medications and purpose _____
_____
_____

OTHER INJURIES AND MEDICAL CONDITIONS

As a reminder, it is critical that you fully answer the following questions. The Department of Labor and Industries must consider all pre-existing and industrially-related physical and/or mental health limitations and disabilities when evaluating a worker's ability to work. Therefore, we urge you to disclose the existence of any medical conditions regardless of whether they pre-existed or are related to your industrial injury or occupational disease.

Before Injury/Disease

Describe any previous L&I injuries/claims and approximate dates? _____
_____
_____
_____

Describe any other non work-related injuries or accidents that happened before this industrially related injury or disease occurred _____
_____
_____
_____

Have you ever received money for previous injuries/accidents?_____
If so, please explain _____
_____

Did the industrially related event(s) aggravate any pre-existing condition(s)?_____
If so, describe how _____
_____
_____

Was any pre-existing condition causing limitations at the time of this industrial injury/disease?__
If so, describe _____
_____
_____

List any other significant medical conditions you had or have had before industrial injury/disease
_____
_____
_____

Have you ever seen a mental health professional before the industrially related condition?_____
If so, indicate approximate dates_____
_____

After Industrial Injury/Disease

Describe any accidents or injuries that occurred after the industrially related event(s) _____
_____
_____
_____
_____

Describe any other general medical conditions diagnosed after the industrially related event(s)
_____
_____
_____

Have you seen or been referred to a mental health professional after the industrially related event(s)?
If so, please explain_____
_____

VOCATIONAL

Employer at time of injury _____
Position _____
_____
_____

Are you still employed by same employer? _____ If no, were you terminated or quit? _____
Date of separation from employment _____
Did you return to work at any time after the injury/disease? _____
If so, name of employer? _____
Position _____ Was your job modified to accommodate injury? _____
If so, how? _____
Were you/are you paid the same amount as time of injury? _____
Did you work the same number of hours? _____

Are you currently employed? ____ If not, why not? _____ Date last worked? _____

Describe all efforts to work or obtain work since injury/disease? _____
_____
_____
_____
_____

Work History: (List name of all employers in past 15 years, job title, and approximate length of employment)

_____

_____

_____

_____

_____

_____

_____

Describe educational background and any special skills or training _____

_____

_____

_____

Do you have a current driver's license? _____

Have you ever been convicted of a crime? _____ If so, please explain _____

_____

_____

_____

Is there any additional information you think we should know about you?

_____

_____

_____

_____

_____

The foregoing information is true and correct to the best of my knowledge.

_____

Signature Date