MALLERY & STERN

CLIENT INTAKE SHEET

Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone No.: (___) _____ (___) _____ (___) _____
Home Work Other

Is there a friend / relative that we can contact if you cannot be reached?

Name _____ Relationship _____ Telephone No. _____

Date of Birth _____ Social Security No.: ___ - ___ - ___

Driver's Licence No.: _____

Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Occupation: _____ May we contact you at work? Yes_____ No___

How did you select this firm _____

Signature _____ Date _____

Office Use Only

Prepared by: _____ Acct. No. _____ Partner: _____
Type of case: _____ Statute: _____ Fees: _____

Referring Attorney _____ Address _____ Referral Fee _____

Comments: _____

EMPLOYMENT AND INJURY INFORMATION

Union membership, if any _____

Employers' workers' compensation carrier _____

Name_____

Address_____

City, State, Zip _____

[redacted] phone (____) _____ Ext _____

Claim examiner_____

Claim number _____

Employer at time of injury _____

Name_____

Address_____

City, State, Zip _____

Home phone (____) _____ Ext _____

Immediate supervisor_____ Title_____

Date of hire _____

Job title _____

Job duties:_____

_____

_____

_____

Was this a permanent job? (____) Yes (____) No

If it was a temporary job, how long would the job have lasted if the injury had not happened? _____

Earnings at time of injury $_____ per _____

Based on _____ hours per day and _____ days per week_____

Other benefits (___) tips _____ (___) overtime

(___) uniform_____ (___) meals _____

(___) lodging_____(___) mileage_____

(___) other_____

Earnings for the year prior to the accident _____

Did you have a second job at the time of the injury? _____

What was it? _____

If you had continued to work, would you have been entitled to any salary increases? (____) Yes (____) No

If yes, explain_____

_____

Has the employment been terminated?

If yes, date _____, reason_____

INJURY INFORMATION

Date of injury _____ Time _____

Location of accident_____

_____

How accident happened _____

_____

_____

_____

_____

Was the injury caused by another person, company, or machinery?

(___) Yes (___) No

If yes, who or what? _____

How?_____

_____

_____

_____

Parts of body injured_____

Type of injury (for example, fracture, herniation, heart attack, cancer, allergies, etc.) _

_____

_____

Parts of the body where you still have pain or other difficulty as a result of the work injury, with short description _____

_____

_____

Who was the accident reported to? (name) _____

Title _____

When _____

How _____

Witnesses to accident (give us their names and have them contact us)

_____

_____

_____

_____

Time lost from work due to injury:

From _____ to_____

From_____ to _____

From _____ to _____

Was TD paid? (___) No (___) Yes, at $_____ per week

From _____ to _____

From _____ to _____

From _____ to _____

Since the date of the injury, have you received:

(___) State Disability Insurance (SDI) or Employees' Disability Insurance (EDD) for the period _____ to_____at the rate of $_____per week.

(___) Unemployment Insurance for the period_____ to _____ at the rate of $_____per week.

(___) Long Term Disability Insurance (LTD) for the period_____ to at the rate of $_____ per week.

Name of carrier_____

MEDICAL TREATMENT

( ) Employer supplemental pay at the rate of $_____ per____for the period of _____ _____ through _____.

( ) Vocational rehabilitation benefits at the rate of $_____per _____ for the period _____ through _____.

If Kaiser member (past or present), Med Record Number _____

Who has paid for your medical care?

(_____) workers' compensation carrier (_____) employer

(_____) Medi-Cal (_____) group carrier (_____) self (_____) unpaid

Name of group carrier_____

Health care providers who have treated or examined you since the accident:

Hospitals

A. Name_____

Address_____

City, State, Zip _____

Dates: _____

(____) x-rays (____) MRI (____) CT (____) ER

(____) other _____

B. Name_____

Address_____

City, State, Zip _____

Dates: _____

(____) x-rays (____) MRI (____) CT (____) ER

(____) other _____

(__) other _____

PHYSICAL THERAPY

Where _____

When_____

Prescribed by_____

Date of next visit _____

DOCTORS

Dr. _____ Phone (____) _____

Address_____

City, State, Zip _____

Specialty _____ Sent by_____

Dates _____

Treatment _____

Date of next visit _____

Dr. _____ Phone (____) _____

Address_____

City, State, Zip _____

Specialty _____ Sent by_____

Dates _____

Treatment _____

Date of next visit _____

Dr. _____ Phone (____) _____

Address_____

City, State, Zip _____

Specialty _____ Sent by_____

Dates _____

Treatment _____

Date of next visit _____

PREVIOUS INJURIES OR CLAIMS

Have you had any injuries on the job before this one? (____) No (____) Yes

Date	Type of Injury	Attorney	Status of Claim

Have you had any injuries off the job before this one? (____) No (____) Yes

Date	Type of Injury	Attorney	Status of Claim

Do you have any other disabling illnesses, such as heart disease, emphysema, arthritis, hearing or vision loss, etc?

Comments: _____